ANNEX B

BEHAVIORAL HEALTHCARE SYSTEM ASSESSMENT

Operation Iraqi Freedom (OIF-II)
Mental Health Advisory Team (MHAT-II)

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Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the Behavioral Healthcare System in OIF-II, including Kuwait and Iraq. The findings were obtained via direct observation, interviews, surveys, and data calls.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

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INTRODUCTION

One objective of the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) was to conduct an assessment of the Army behavioral healthcare system in Kuwait and Iraq. The focus was to assess Army-wide policies, procedures, and resource requirements affecting behavioral health (BH) services in theater and to provide recommendations to address potential organizational and resource limitations. To accomplish this goal, MHAT-II gathered information by using three written anonymous surveys (one for behavioral healthcare providers, one for unit ministry teams (UMTs), and another for primary medical care providers), an interview schedule for behavioral healthcare providers, and a series of data calls from BH units.

Within the annex, the overall findings and recommendations for the OIF-II behavioral health system are presented first. These overall findings and recommendations draw from the findings and recommendations of the BH, primary care (PC), and UMT surveys, interviews with BH personnel, and various data calls found within the appendices.

FINDINGS

Finding #1: As reported in Annex A, Soldiers are experiencing numerous combat stressors; however, noncombat deployment stressors related to quality of life and Soldier mental health (MH) and well-being have shown improvement since OIF-I.

Although OIF-II Soldiers are experiencing numerous combat stressors and the majority (54%) rates their morale as low or very low, the noncombat deployment stressors have improved considerably since OIF-I, and the morale and MH have also improved. Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a MH problem in OIF-II compared with OIF-I (13% vs. 18% respectively). In addition, 40% of Soldiers with MH problems reported receiving professional help during the OIF-II deployment, significantly higher than the 29% of Soldiers with MH problems who received professional help in OIF-I. Stigma and organizational barriers to receiving care are still problems. Fifty-three percent of Soldiers with MH problems perceived that their leaders would treat them differently, 39% reported that it would be difficult getting time off work, and 20% reported that it was too difficult to get to the location of the MH specialist (see Annex A). Other indicators of improvement include lower evacuation rates (see Annex C) and lower suicide rates (from 18 per 100,000 down to 8.5 per 100,000—see Annex D).

Finding #2: The OIF-II behavioral healthcare system is improving.

As noted in Annex G, many of the MHAT recommendations from OIF-I have been or are being implemented. Examples include the appointment of a BH consultant to the Multi-National Corps-Iraq (MNC-I) Corps Surgeons cell, the adoption of Army Suicide Event Reports (ASERs) to track data surrounding completed suicides, improvement in

Soldier access to care (from 29% to 40%), the 23% reduction in the BH evacuation rates, and the improvement of Soldier training in handling the stresses of combat/operational stress (from 29% to 41%). The following findings support the fact that the BH system is improving:

Supportive Finding #2a: Most BH personnel in theater report conducting outreach on a regular basis, despite challenges of working in the operational environment.

Sixty-nine percent of BH personnel surveyed reported that they were conducting combat and operational stress control (COSC) outreach services either weekly or several times a week, and 71% reported consulting with unit leaders once a week or more. Behavioral healthcare personnel reported they were actively involved in conducting educational classes, psychological debriefings, and suicide prevention training. They also indicated they were providing services at the Soldiers' worksites as well as their own.

In addition, COSC principles were more readily accepted in OIF-II than in OIF-I. In OIF-II, 78% of those surveyed disagreed with the statement, "Behavioral health/COSC personnel don't think preventive outreach activities are effective," and only 5% agreed with this same statement. Further, 74% disagreed with the statement that providers don't like to perform outreach. These rates show a more positive acceptance to outreach activities when compared to two questions, of a similar nature, that were asked during OIF-I. Operation Iraqi Freedom (OIF-1) providers were asked, "How relevant is COSC doctrine to current operations?" Forty-four percent of the junior enlisted, 35% of the noncommissioned officers (NCOs), and 45% of the officers agreed that it was relevant. Also, fewer people (57%) of the BH personnel in OIF-I agreed COSC was the best method of early intervention.

Supportive Finding #2b: Coordination is occurring between BH personnel, UMTs, and PC providers, and over 75% of the UMTs and PC providers reported receiving information on BH services and guidance on how to refer Soldiers to BH personnel.

Seventy-eight percent of the PC providers reported on their survey that BH personnel had given them information about where to refer Soldiers for MH problems, and 76% reported they had received information about the services offered by BH personnel for Soldiers. Many chaplains (83%) reported they had received information from BH personnel on where to refer Soldiers for MH problems, and 88% reported that they had been educated on the services provided by BH personnel for Soldiers.

Supportive Finding #2c: Behavioral health return-to-duty (RTD) rates are high and comparable to OIF-I.

All forward-deployed BH assets in OIF-II Iraq had high RTD rates. One separate brigade BH team returned 100% of the Soldiers/patients evaluated by its Division

Mental Health Section (DMHS). The two DMHS's and another separate brigade's rates were above 96%. The one combat stress control (CSC) company, while deployed at 15 forward operating bases (FOBs) throughout Iraq, returned 95% of the Soldiers it evaluated. The Air Force's two operational stress teams in Kuwait had RTD rates (97%) comparable to the Army's forward-deployed BH units. A combat support hospital (CSH) returned 80% of the psychiatric patients it evaluated and treated.

Supportive Finding #2d: Both the number of BH personnel in theater and the ratio of BH personnel to Soldiers are higher in OIF-II than in OIF-I.

Last year (OIF-I), 163 BH personnel (psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, enlisted MH specialists, and occupational therapy (OT) technicians) provided services for an estimated 138,000 Soldiers in Kuwait and Iraq in September 2003. The overall ratio of BH personnel to Soldiers was 1/851. As of 1 October 2004, 232 BH personnel (see Table 1) are providing services to an estimated 94,500 Soldiers in Kuwait and Iraq, for a ratio of 1/407—a ratio over twice that of OIF-I. Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage.

In Kuwait, Navy and Air Force personnel were providing most BH coverage. Other than a few Army staff members (b)(2)-2 Navy personnel performed the bulk of the primary medical care, and (b)(2)-2 Air Force combat stress teams (CSTs) performed all of the BH prevention and early intervention (See Tables 2 and 3). Based on Soldier population, there are fewer BH personnel in Kuwait (1/656 overall) than in Iraq (1/388) where the need is greater due to operational stressors.

Supportive Finding #2e: Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I.

Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I. The OIF-II ratios varied from 1/160 to 1/888 (with a standard deviation of 227), while the OIF-I ratio of BH personnel to Soldiers varied from zero (no BH personnel) to 1/3,292 by region (with a standard deviation of 1,038). Further, 76% of Soldiers live on FOBs where BH personnel are collocated (Note: For simplicity, "FOB" includes base camps, logistical support areas, ranges, etc., in Kuwait and Iraq). In general, as the size of the FOB population decreased, the number of BH personnel to Soldiers also decreased, and the variance in the distribution of BH personnel within each size category increased.

Forward operating bases that did not have on-site BH personnel may have received services from BH personnel at neighboring FOBs. Data from the Soldier Health and Well-being Survey showed that overall, Soldiers on smaller FOBs reported nearly identical rates of utilization of MH services as Soldiers on larger FOBs. On FOBs with Soldier populations less than or equal to 1,000 in size, 11% of Soldiers saw a MH or

CSC professional during the deployment, compared with 9% of Soldiers on FOBs that had a population of 1,001-3,000, and 11% on FOBs over 3,000.

Supportive Finding #2f: Combat stress control units, medical companies with MH sections, and CSHs can manage routine and surge period demands for holding Soldiers with BH problems.

On both routine and on an emergent basis, "holding capacity" is available at CSC units and at brigade, division, and area support medical companies (ASMCs). The CSC units have the capability to set up many more Level II cots for stress and psychiatric casualties if needed. Each CSH slice is able to admit Soldiers with BH problems on the intermediate care wards. Theater BH personnel interviewed indicated that, in general, a Soldier deemed to require an inpatient level of care is only held long enough to be stabilized, evaluated, and prepared for evacuation out of theater. All of the CSHs have partnered with CSC units to provide synergistic BH treatment and holding services.

Finding #3: The majority of OIF-I Mental Health Advisory Team recommendations has been implemented or is in the process of being implemented. Opportunities for improvement still exist in the OIF-II behavioral health system.

Examples include irregular submission of ASERs on nonlethal suicide attempts, need for a standardized unit BH needs assessment program, need for research on early psychological interventions for traumatic stress exposures, and the improved tracking systems for evacuations (see Annex C). The following findings identify areas where the BH system can improve.

Supportive Finding #3a: While coordination between BH personnel, UMTs, and PC providers is good, coordination could increase between these three professional groups.

Fifty-four percent of the BH personnel reported that they coordinated/integrated BH/COSC activities with the UMTs, and 62% of the PC providers and 61% of the chaplains (58% chaplain assistants), in turn, reported coordinating their MH activities with BH personnel. All three groups are valuable resources for each other and together represent a force multiplier for Soldiers' support. Although the great majority of respondents indicated they were informed of where to refer Soldiers for BH care, increased coordination would further capitalize on the strengths of these three professional groups.

Supportive Finding #3b: Significant challenges remain in providing BH care.

Forty percent of the BH personnel surveyed agreed that there was inadequate transportation to conduct outreach activities, 30% agreed that there was inadequate communication between BH/COSC and supported units, and 27% reported traveling to supported units was too dangerous. Although 40% felt that arranging convoys to supported units was not difficult, 21% reported having to cancel missions due to the inability to arrange convoys.

Supportive Finding #3c: Two thirds of Soldiers reported receiving training in handling the stresses of deployment and/or combat, and less than half reported the training in managing the stress of deployment was adequate.

Sixty-nine percent of the Soldiers reported they had received training in handling the stresses of deployment and/or combat, and 41% reported that the training in managing the stress of deployment was adequate (This rate was higher than the rate of 29% reported by OIF-I Soldiers ($p < .001$)). Twenty-three percent reported not receiving suicide training in the last year. Such training is vital given that a fellow Soldier is often turned to for support. Fourteen percent of all Soldiers stated that they turned to another Soldier in their units for "counseling/MH services for a stress, emotional, alcohol, or family problem." This percentage increased to 26% among those Soldiers who screened positive for MH symptoms (depression, anxiety, or posttraumatic stress disorder (PTSD)).

Supportive Finding #3d: Most BH personnel received pre-deployment refresher training in BH/COSC tactics, techniques, and procedures, but reported additional training is needed.

Behavioral health personnel were more confident in their training this year (OIF-II) due to the pre-deployment refresher training they received, but there were still areas of identified need. Survey and focus group data revealed four key areas that BH personnel perceive the need for further training:

- *Cross-cultural (Iraqi) Evaluation and Treatment.* One in five BH personnel felt confident in their ability to evaluate or treat an Iraqi individual. Given the potential to become involved in detainee or humanitarian operations, this is a vital skill that needs to be addressed.
- *Combat and Operational Stress Control Workload and Reporting System (COSC-WARS).* Forty-seven percent of the BH personnel reported they were confident in their ability to use this system.
- *Sexual Assault Evaluation and Treatment.* Sixty-three percent of BH personnel felt confident in evaluating and/or treating a victim of sexual assault.
- *Substance Abuse Evaluation and Treatment.* Seventy percent reported they were confident in their ability to evaluate and/or treat substance abuse disorders; 30% did not endorse confidence in this ability.

Supportive Finding #3e: Standards of care, documentation management, and statistical reporting methods were unclear to some BH personnel.

Behavioral health personnel report a lack of clarity on clinical and administrative requirements. Fifty-seven percent of the BH personnel agreed that the standards of BH care in theater were clear. Just over half (53%) agreed that COSC service standards were clear.

Documentation management in the theater was clear for less than half of the BH personnel surveyed. Of the BH personnel surveyed, 41% agreed that standards for clinical documentation were clear; 33% reported the standards for records management were clear, and 35% reported the transfer of clinical BH information between levels of care was clear.

Supportive Finding #3f: Behavioral health personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units. A standardized needs assessment process, undergoing development as a result of the OIF-I Mental Health Advisory Team, needs to be implemented.

Although BH personnel report talking informally to Soldiers (92%), medical personnel (77%), unit commanders (71%), and chaplains (71%) to gather data for a needs assessment, less than half use instruments of any kind. Forty-two percent conduct focus groups or locally developed surveys. Thirty-nine percent use validated surveys/instruments. There continues to be a need to provide BH personnel with a standardized Soldier and unit needs assessment tool that can objectively quantify BH needs in order to better plan tailored BH interventions for each unit.

Supportive Finding #3g: Some BH, UMT, and PC personnel are reporting compassion fatigue and burnout.

Thirty-three percent of BH personnel reported high burnout, 27% reported low motivation, and 22% reported low morale. Fifteen percent agreed that the stressors of deployment impaired their BH job; in addition, 12% felt that their sensitivity to the needs of the Soldier had been adversely affected.

Thirty-seven percent of PC personnel reported high burnout, 35% reported low motivation, and 35% reported low morale. Fifteen percent agreed that the stressors of deployment had impaired their medical job, and 14% indicated they had become less sensitive to the needs of Soldiers during this deployment.

Sixteen percent of UMT personnel agreed or strongly agreed that the stressors of the deployment and combat impaired their job. They also reported low or very low personal energy (28%), personal motivation (23%), personal morale (18%), and high or very high personal burnout (33%). Some also reported having their mental (13%) or spiritual (15%) well-being adversely affected by combat or deployment stressors.

Table 1 presents the percentages of officers and enlisted members of the three various groups (BH, PC, and UMT) who report adverse effects of deployment and/or low morale. Primary care personnel have significantly lower morale ($p<.001$) and lower personal motivation ($p\leq.002$) than BH and UMT personnel. Primary care personnel also reported significantly less sensitivity to the needs of Soldiers than UMT personnel ($p\leq.002$). Pooled together, the officers reported significantly less adverse effects from the deployment, higher morale, and lower burnout than enlisted providers (all $p<.001$).

Table #1: Comparison of Compassion Fatigue and Burnout Among Provider Types

	% of BH	%Prim Care	% of UMT
Officers	**(n = 62)**	**(n = 140)**	**(n = 89)**
Ability to do **job is impaired** by stressors	13.1	9.5	14.6
Mental well-being adversely affected	6.6	8.7	15.7
Spiritual well-being adversely affected	9.8	13.0	7.8
Less sensitive to Soldiers' religious/spiritual needs	0	10.0	3.3
Ability to do job is **impaired by listening** to combat experiences	1.6	0.7	3.3
Personal **morale** (Low or Very Low)	14.5	24.3	11.2
Energy level (Low or Very Low)	14.5	20.7	23.5
Level of **burnout** (High or Very High)	26.3	26.6	26.1
Motivation (Low or Very Low)	14.5	20.1	17.1
Enlisted	**(n = 74)**	**(n = 101)**	**(n = 86)**
Ability to do **job is impaired** by stressors	15.1	21.6	16.5
Mental well-being adversely affected	11.0	22.7	10.6
Spiritual well-being adversely affected	9.6	17.5	17.7
Less sensitive to Soldiers' religious/spiritual needs	21.9	18.6	9.5
Ability to do job is **impaired by listening** to combat experiences	10.9	7.2	6.0
Personal **morale** (Low or Very Low)	25.7	48.5	24.4
Energy level (Low or Very Low)	28.4	38.6	32.5
Level of **burnout** (High or Very High)	38.3	53.7	41.2
Motivation (Low or Very Low)	36.9	55.6	29.1

RECOMMENDATIONS

Recommendation #1: Continue forward-deployed outreach to facilitate Soldier access to BH services.

Aggressive outreach may be one of the reasons for the increase in utilization of BH services (from 29% to 40% from OIF-I), and it should continue. Behavioral health personnel are better distributed in OIF-II than in OIF-I.

Recommendation #2: Ensure all BH personnel can provide (with supervision and medical support) the full range of BH services.

It is important to maintain strong coordination amongst the various BH personnel in theater (whether from division, CSC units, CSH, etc.) to assure that Soldiers have access to BH services when needed. Personnel who conduct outreach at the unit level or are the sole provider at a particular location should be able to provide the range of services to include clinical evaluation and treatment, triage, facilitation of restoration in local medical companies, referral to the next level of care, prevention, consultation, and education. Likewise, clinical staff at large FOBs (at CSHs, CSC restoration facilities, etc.) should be able to provide outreach routinely. While existing COSC doctrine (FM 8-51, 1998) has traditionally divided tasks into prevention, restoration, and treatment, BH personnel need to be able to do all of these functions.

Recommendation #3: Improve Soldier and leadership training in BH Issues.

Since Soldiers turn to their peers for help in crises under combat conditions, it is imperative that Soldiers and leaders be trained in how to provide support and/or refer their peers and subordinates with BH issues to BH personnel. The BH personnel in theater provide this training during outreach. It should be enhanced in officer and enlisted schools, ongoing officer and NCO development programs, and during pre-deployment and post-deployment briefings.

Recommendation #4: Develop and field an automated BH preventive and clinical documentation and reporting system for use in theater.

Theater leadership should set policy requiring a single format for documenting and reporting all BH preventive and clinical services. Assess if an existing system (such as COSC-WARS) meets the requirements and ensure that whatever system is approved is implemented theater-wide.

Recommendation #5: Complete development and fielding of a unit needs assessment program and survey tool.

Last year, the MHAT recommended that a standardized needs assessment program and tool be developed and fielded to all BH assets. This need was recognized again this year. The United States Army Medical Research and Materiel Command (USAMRMC) should be tasked to complete and field this program/tool.

Recommendation #6: Utilize an empirically derived staffing model for BH personnel allocation and distribution.

Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater, providing a ratio of 1:851 BH personnel to Soldiers. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage. The ratio of BH personnel to Soldiers in OIF-II is 1:407, substantially different than last year.

Future staffing decisions need to take into consideration the operational environment in theater, the overall Army operations tempo (OPTEMPO), and other factors. Military planners need to tailor the BH force package based on the size of the force, the distribution of the force (number of FOBs), the amount/type of services desired in theater (see Appendix 5, TAB A for full discussion of staffing model), and the availability of personnel and resources to provide this staffing level.

Utilizing the methodology in Appendix 5, TAB A, the MHAT is proposing the use of a theater-wide staffing model to improve BH personnel utilization and enhance coverage of the theater. However, regardless of the model used, it should be needs based and empirically grounded.

Recommendation #7: Finish publication of updated field manual (FM).

The 1994 CSC field manual (FM 8-51), with minor updating in 1999 for the Medical Reengineering Initiative, has not kept up with the vast shifts in doctrine since entering the Global War on Terror. Because it remains the "official" doctrine—sometimes in opposition to last year's MHAT findings and recommendations, BH personnel in the field are confused as to which "doctrine" to follow. It is imperative that the FM be rewritten to reflect the many changes in Army and COSC practice and evolving doctrine noted in the OIF-I Mental Health Advisory Team report.

Those changes have been drafted by the MHAT for incorporation into the programmed successor to FM 8-51, FM 4-02.51. Changes noted in doctrine from this report should also be integrated into the draft and then published as quickly as possible.

Recommendation #8: Complete development of behavioral health COSC course.

As recommended by last year's MHAT, and as part of the indoctrination and preparation of BH personnel—both active and reserve—is the creation of an "all disciplines" COSC course. This 2-week Army Medical Department Center and School (AMEDDC&S) course will serve as a foundation course for all BH disciplines in combat and battlefield BH doctrine and practice. This course should be a requirement of all new BH officers within their first year of service. Further, all BH officers should be required to attend this course upon accepting a table(s) of organization and equipment (TO&E) or Professional Filler System (PROFIS) assignment. A 1-week refresher/update course should also be created for those who have attended the basic COSC course and need an update prior to a TO&E assignment and/or deployment.

Recommendation #9: Publish a compendium of best practices.

Another OIF-I Mental Health Advisory Team recommendation that was revalidated this year is the need for a "compendium of best practices" from the field. This compendium could reside at the Center for Army Lessons Learned at the AMEDDC&S and at the United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) or another appropriate site available to all BH personnel.

Recommendation #10: Web-based BH prep for deployment (OIF Newcomers Orientation Training)

Computer access in theater is improved, and most BH personnel in OIF and Operation Enduring Freedom (OEF) have access to a computer with Internet linkup. Given the disperse nature of both BH personnel in the continental United States (CONUS) prior to deployment, and the disperse nature of the teams in theater during deployment, on-demand, web-based training may be the best way to reach the vast majority of BH personnel. For those unable to access web-based training, printed materials or CD-ROM formats should also be made available. Behavioral health personnel could access Programs of instruction (POIs) throughout the entire deployment cycle (prior to

mobilization, during mobilization, during deployment, and during post-deployment and de-mobilization). Changes in doctrine, techniques, and policy could be centralized for on-demand retrieval. Further, core course work could be programmed with feedback to commanders, BH consultants, and other leadership to ensure that those officers and enlisted members under their jurisdiction have completed the courses as required. These core courses could be particularly helpful for the reserve physicians who rotate in for only 90 days. They must be able to "get up to speed" very quickly. A short hour, web-based POI would cover the medical and BH policies and procedures currently in place, familiarize them with the theater (in general, unclassified, terms), etc.

Recommendation #11: Research and implement a program for burnout and compassion fatigue.

As noted in the findings above, a third of BH, medical, and pastoral counseling personnel are experiencing burnout, compassion fatigue, and other professional impairments since being deployed. If one third of our providers are impaired, our ability to intervene early and assist Soldiers with their problems may be degraded.

In addition to studying Soldiers to better understand the products and processes of combat-induced trauma and deployment deprivation, it is vital to understand the processes of provider burnout in order to prevent and intervene in order to preserve the care in our caregivers.

Recommendation #12: Continue to appoint a BH consultant to the area of responsibility (AOR) Surgeons cell to advise the Surgeon on BH issues.

The OIF-II behavioral health consultant has been instrumental in advising the Surgeon on distribution of BH assets in theater for the delivery of BH care in the AOR; coordinating training and providing BH personnel consultation support; and consulting with the Surgeon on BH matters. Having a BH consultant to oversee the planning, coordination, and integration of BH assets in theater will help to ensure continuity of BH services delivery in theater during OIF-III.

APPENDIX 1

SUMMARY OF BEHAVIORAL HEALTH (BH) SURVEY

INTRODUCTION

The objective of the BH Survey was to gather data to assess the BH care services being rendered during OIF-II and provide recommendations based on the findings. Behavioral health personnel is defined in this section as officer and enlisted personnel who provide BH services to Soldiers.

FINDINGS

Finding #1: Standards of care for BH and COSC services and standards for documentation, records management, and transfer of clinical BH information are clear for most BH personnel. However, about one third of the BH personnel are unclear on documentation policies.

Behavioral health personnel were asked how clear the standards of BH/COSC services and documentation were to them. Fifty-seven percent agreed the standards of BH care in theater were clear, while 23% disagreed (20% were neutral). The standards of COSC services were clear for 53% and unclear for 23% of the BH personnel surveyed.

Documentation management in the theater was not clear for over one third of those surveyed. Behavioral health personnel agreed that standards for clinical documentation (41%), records management (33%), and transfer of clinical BH information between levels of care (35%) were clear. However, 33% indicated documentation standards were not clear, 39% reported records management was not clear, and 31% believed the standards for transfer of clinical BH information between levels of care in theater were not clear.

This finding indicates the need to provide training for deploying BH personnel on standards of care and documentation management. In some instances, Theater, the Army Medical Department (AMEDD), the Army, or the Department of Defense (DoD) may need to clarify policies.

Finding #2: Coordination is ongoing between BH personnel, UMTs, and PC providers.

Fifty-four percent of the BH personnel agreed they coordinated/integrated BH/COSC activities with the UMTs, and 73% coordinated/integrated their activities with PC providers. Sixty-two percent of the PC providers and 61% of the chaplains (58% chaplain assistants), in turn, reported coordinating MH activities with BH personnel. Results indicate coordination between these three groups is underutilized. All three groups are valuable resources for each other and together represent a force multiplier for Soldier support.

Seventy-eight percent of the PC providers reported on their survey that BH personnel had given them information about where to refer Soldiers for MH problems, and 76% reported they had received information about the services BH personnel had offered for Soldiers. Chaplains (83%) reported that BH personnel provided them with information on where to refer Soldiers for MH problems, and 88% had been educated on the services that BH personnel provided for Soldiers. Although the great majority of respondents indicated they were informed of where to refer Soldiers for BH care, further coordination would capitalize on the strengths of these three professional groups.

Finding #3: Many BH providers reported inadequate coordination with their higher headquarters.

Thirty-nine percent of BH personnel reported their higher headquarters (HHQ) did not encourage them to provide feedback/comments regarding theater BH/COSC policies; 34% reported their HHQ did encourage feedback. Thirty-one percent agreed their HHQ provided resources required to conduct the BH/COSC mission, while 46% disagreed.

Two questions addressed medical leadership and line leadership in support of BH/COSC activities. Seventy-six percent of respondents believed medical leadership supports BH/COSC activities; 7% disagreed. Sixty-nine percent felt the leadership of the units they worked with supported BH/COSC activities; 11% disagreed.

Finding #4: Most BH personnel in theater report conducting outreach on a regular basis, despite challenges of working in the operational environment.

Behavioral health personnel were asked how frequently they provided services listed in Table 1. Sixty-nine percent were conducting COSC outreach services either weekly or several times a week, and 71% reported consulting with unit leaders once a week or more. Behavioral health personnel reported they were actively involved in conducting educational classes, psychological debriefings, and suicide prevention training. They also indicated they were providing services at the Soldiers' worksites as well as their own.

Table 1: Provider Responses to Questions on Frequency of Service Delivery

The numbers in the columns below (1 through 7) are percentage rates of the response for each question a. through j. Below the chart is the definition key for each numeral 1-7.

BH/COSC Services	(% of Respondents)						
During this deployment, how frequently did you:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
a. Provide COSC outreach services?	6	2	6	6	10	13	56
b. Conduct educational classes?	10	1	5	11	9	17	47
c. Consult with unit leaders?	6	3	3	7	11	22	49
d. Conduct psychological debriefings (CED/CISD)?	22	10	14	11	29	9	6
e. Conduct systematic unit needs assessments?	36	11	14	17	14	5	4
f. Conduct Suicide Prevention Training?	34	12	17	12	15	8	4
g. Provide one-to-one BH counseling with Soldiers at their worksite?	23	3	11	10	11	13	30
h. Provide one-to-one COSC services with Soldiers at their worksite?	23	5	9	8	10	14	31
i. Provide one-to-one BH counseling with Soldiers at your worksite?	9	2	4	4	5	11	65
j. Provide one-to-one COSC services with Soldiers at your worksite?	12	3	4	4	8	12	57

1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;
5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

Seventy-eight percent of those surveyed disagreed with the statement, "Behavioral health/COSC personnel don't think preventive outreach activities are effective" while 5% agreed with this statement. Seventy-four percent disagreed with the statement that providers don't like to perform outreach. These rates show a more positive acceptance to outreach activities when compared to two questions, of a similar nature, that were asked during the MHAT-I survey. Operation Iraqi Freedom (OIF-I) providers were asked, "How relevant is COSC doctrine to current operations?" Only 44% of the junior enlisted, 35% of the NCOs, and 45% of the officers agreed that it was relevant. Also, 57% of the BH personnel in OIF-I agreed COSC was the best method of early intervention.

It is important to note that 50% of the BH personnel in OIF-I reported they had not received adequate training in COSC, prior to deploying. Driven by these findings, the combat stress control BH consultant ensured units supporting OIF-II received "just in time training," prior to their deployment. Training teams were dispatched to the units' locations for 2 to 3 days of intensive COSC instruction. A portion of this training emphasized the importance for outreach.

Significant challenges remain that impact the BH providers' ability to provide care. Forty percent of the BH personnel agreed that there was inadequate transportation to conduct outreach activities, 30% agreed that there was inadequate communication between BH/COSC and supported units, and 27% reported traveling to supported units was too dangerous. Forty percent felt that arranging convoys to supported units was not difficult; however, 21% reported having to cancel missions due to the inability to arrange convoys.

Finding #5: Behavioral health personnel are confident in their ability to treat Soldiers with combat stress, suicidal thoughts/behaviors, or PTSD. They are not as confident to treat Soldiers with substance abuse/dependence, victims of sexual assault, or Iraqi people.

Behavioral health personnel expressed varying degrees of confidence in their ability to treat the following conditions listed in Table 2. These questions began with the phrase, "I feel confident in my ability to..." followed by each of the statements listed below.

Table 2: Confidence to Treat Varying Conditions

	% Who	
I feel confident in my ability to:	**Agreed**	**Disagreed**
Help Soldiers adapt to the stressors of combat/deployment.	95%	1%
Evaluate and manage Soldiers with suicidal thoughts/behaviors.	94%	1%
Evaluate and treat Soldiers with substance abuse/dependence.	70%	9%
Evaluate and treat combat and operational stress reaction.	94%	2%
Evaluate and treat acute stress disorder/PTSD.	91%	3%
Evaluate and treat victims of sexual assault.	63%	10%
Perform clinical evaluation and treatment of Iraqi civilians.	20%	44%
Perform clinical evaluation and treatment of detainees.	23%	42%
Perform clinical evaluation and treatment of Iraqi security force personnel.	22%	61%

It is evident that further training is needed to prepare BH personnel to manage Soldiers experiencing substance abuse/dependence, PTSD, and sexual assault.

Finding #6: Psychiatric medications in OIF-II were more readily available than they were during OIF-I at each level of care, but Levels I and II continue to have limited availability of psychiatric medications for those who are credentialed to prescribe.

Seventy-seven percent of the psychiatrists and nurses who had prescriptive authority reported adequate availability of appropriate psychiatric medications. Twenty-three percent disagreed. During OIF-I, only 36% of the psychiatrists and nurses felt that there was an adequate supply of psychiatric medication, an improvement from last year. Levels I and II continue to be perceived by some as problematic. The higher the level of care, the more available the medication became as 47% reported adequate availability of psychiatric medication at Level I (the battalion aid stations (BASs)); 78% reported adequate availability at Level II (the forward support medical company (FSMC)); and 94% reported adequate availability at Level III (CSHs). Providers were asked to list the medications that Soldiers needed at each level of care; the longest list was with Level I (there were a total of 14 medications listed). Of these 14 medications, only three were repeated twice on the list, Effexor, Zyban, and Zyprexa. For the medications listed, see Table 3. Level II had eight listed with only one medication, Olanzapine, which was listed twice. Level III had only one medication listed.

Table 3: Medications Needed at Each Level of Care

Level of Care	Medications not Available to Prescribe
Level I	Ambien *, Buspar, Depakote (Extended Release), Effexor, Olanzapine, Prazosin, Remeron, Seroquel, Strattera, Trazadone* Wellbutrin XR**, Zyban, Nicoderm patch
Level II	Concerta, Lexapro, Paxil*, Prazosin, Remeron, Seroquel, Sonata, Olanzapine
Level III	Seroquel

*** Approved for the medical equipment set at Level I, May 2004**

**** Approved for the medical equipment set at Level II, May 2004**

During this past year, a process action team (PAT) of psychiatrists recommended additions to the psychiatric medication formulary in the medical equipment set's (MES's) sick call (Level I), patient holding (Level II), and the CSH pharmacy. The Directorate of Combat and Doctrine Development's (DCDD's) combat casualty care integrated concept team approved the additions in May 2004, and the MESs will be updated to incorporate these changes. Also added were Celexa at Level I and Prozac and Zoloft at Level II. Space available for basic loads of medications at Levels I and II is very limited, while special medications can be supplied on request from a CSH or through Medical Logistics. The theater BH consultants (Kuwait and Iraq) are working with the pharmacy officer in the Corps Surgeon's office on a theater-wide formulary, following data collected from providers in theater.

Finding #7: A quarter (25%) of the BH personnel surveyed reported a lack of confidence in their ability to use the COSC-WARS.

Forty-seven percent of the BH personnel reported they were confident in their ability to use the COSC-WARS. Twenty-eight percent neither agreed nor disagreed.

Finding #8: Behavioral health personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units. Thirty-nine percent are using validated surveys/instruments.

Behavioral health personnel were asked how they assessed the BH/COSC needs of the units and the Soldiers they support. Ninety-two percent reported they talk informally to Soldiers; 77% talk to unit medical personnel; 72% talk with unit commanders; 71% talk to chaplains; 42% conduct focus groups; 42% use locally developed surveys; and 39% use validated surveys/instruments. These are effective methods, but there continues to be a need to provide BH personnel with a standardized Soldier and unit needs assessment tool that can objectively quantify BH needs and needs of the Commander.

Finding #9: One third of BH personnel are experiencing burnout.

Thirty-three percent of BH personnel reported high burnout, 27% reported low motivation, and 22% reported low morale. Fifteen percent agreed that the stressors of deployment impaired their BH job; in addition, 12% felt that their sensitivity to the needs of the Soldiers had been adversely affected.

BACKGROUND

Survey Methods and Procedures

The OIF-II Mental Health Advisory Team (MHAT-II) designed the BH survey. The questions were devised by consensus of the team members to gather data on a variety of topics of interest to the MHAT-II mission, such as standards of practice, provision and coordination of services, skills and training in relation to compliance and understanding of COSC doctrine, involvement in suicide prevention, perceived stigma and barriers to MH care, and resource deficits. A copy of the instrument can be found at TAB A.

The MHAT-II traveled throughout the Kuwait Combined Forces Land Combat Command (CFLCC) and the Iraq MNC-I operational theaters and administered surveys and conducted interviews with BH personnel between 28 August and 30 September 2004. All BH personnel who the MHAT-II contacted were asked to complete the survey regardless of their current work assignment or unit. Participants were briefed on the mission and informed that the survey was both anonymous and voluntary. All BH personnel asked to complete the survey chose to participate.

Quality Control of Data

The MHAT-II collected a total of 137 surveys from BH personnel throughout Kuwait and Iraq and hand-entered the data into a Microsoft (MS) Access database. A 10% quality control (QC) was performed on the dataset to check for entry errors. Each and every one of the survey fields was read aloud by one staff member, while another staff member checked the hand-entered MS Access database.

Fifteen (15) out of 137 surveys were quality checked. Each survey contained 97 fields, for a denominator of 1455. Results revealed a total of 1 error (in the comment field). The error rate for all mistakes was 1/1455 or .069%, well within the acceptable 0.2% limit.

Comparison Populations

Data from the OIF-I behavioral health survey, conducted between 29 August and 30 September 2003, are included in this report when comparisons of similar questions can be made. Most of the behavioral health OIF-II survey questions were altered to better quantify the participants' response and to also capture the changes made in the BH system between 2003 and 2004.

Study Sample

A convenience sample of 137 (59%) of the 232 (as of 1 October 2004) Iraq and Kuwait BH providers and enlisted MH specialists completed the survey at 17 locations around theater. Sixty-three percent of the survey respondents were age 30 or more. The rank distribution is as follows: junior enlisted Soldiers 28%, NCOs 27%, and officers 46%. Thirty-nine percent of all surveyed were active component, 52% Army Reserve, and 9%

National Guard. Ninety-six percent of the participants were Army, 2% were Navy, and 2% were Air Force. Sixty-five percent of the sample was male.

Participants had been deployed an average of 210 days (7 months) over the past 2 years; 25% said 1 year. Ninety-five percent of those surveyed reported currently working in their BH job. Table 4 shows the types of personnel represented in the survey.

Table 4: AOCs and MOSs Represented in the BH Survey

AOC/MOS	Description	Number	Percent of Respondents
60W	Psychiatrists	19	14%
65A	Occupational Therapists (OT)	5	4%
66C	Psychiatric Nurses	7	5%
73A	Social Workers	20	15%
73B	Clinical Psychologists	10	7%
91WN3	OT Assistants	7	5%
91X	Mental Health Specialists	62	46%
Other	Other/Did not Answer	7	4%

TAB A: Behavioral Health (BH) Survey

Behavioral Health/Combat and Operational Stress Control Personnel Survey

This survey is being conducted under the auspices of The Army Surgeon General's OIF Mental Health Advisory Team (MHAT). The purpose of this questionnaire is to gather data about the current mental well-being of Soldiers and behavioral health personnel in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Definitions: In this survey, Combat and Operational Stress Control (COSC) is used synonymously with preventive, educational and outreach services, and the management of combat and operational stress reactions (COSRs) as described in FM 8-51. Behavioral health (BH) is used synonymously with clinical care for behavioral health disorders (i.e., evaluation and treatment).

Today's Date: _____

Please circle the number of the category that best describes you.

A. DEMOGRAPHICS

Age:	*Gender:*	*Grade/Rank:*	*Primary Component:*
1 = 18-20	1 = Male	1 = E1–E4	1 = Active Component
2 = 21-24	2 = Female	2 = E5–E6	2 = Reserve (USAR)
3 = 25-29		3 = E7–E9	3 = National Guard
4 = 30-39		4 = O1–O3	4 = AGR
5 = 40 or older		5 = O4–O6	5 = Individual Ready Reserve (IRR)
		6 = WO1–WO5	

MOS/AOC:	*Which region best describes where you are currently serving?*	*For THIS deployment, please indicate the MONTH/YEAR you arrived in theater:*
1 = Psychiatrist (60W)	1 = Northern Iraq (Mosul area)	
2 = Occ Therapist (65A)	2 = North East Iraq (Kirkuk area)	
3 = Psych Nurse (66C)	3 = North Central Iraq (Tikrit/Balad area)	
4 = Social Worker (73A)	4 = Central Iraq (Baghdad area)	
5 = Clin Psychologist (73B)	5 = South Central Iraq (Karbala to Nasiriyah)	*How long (MONTHS) should a deployment last?*
6 = OT Specialist (91WN3)	6 = South Iraq (Basra area)	
7 = MH Specialist (91X)	7 = North Kuwait (Udairi, Virginia, etc.)	
8 = Other: _____	8 = South Kuwait (Doha, Arifjan, etc.)	
	9 = Other: _____	

How many TOTAL DAYS have you been deployed (combat or peacekeeping) in the **past 2 years**?	
How many MONTHS have you been assigned to your current unit?	
How many MONTHS has your current unit been deployed to Iraq/Kuwait?	
Are you **currently** working in my BH/COSC job?	Yes / No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

B. STANDARDS	
1. The standards of BH care in this theater/Area of Operations are clear.	1 2 3 4 5
2. The standards of COSC services in this theater/Area of Operations are clear.	1 2 3 4 5
3. The standards for clinical documentation in this theater/Area of Operations are clear.	1 2 3 4 5
4. The standards for records management in this theater/Area of Operations are clear.	1 2 3 4 5
5. The standards for transfer of clinical BH information between levels of care in this theater/Area of Operations are clear.	1 2 3 4 5

C. COORDINATION	
1. My higher headquarters provides us with the resources required to conduct our BH/COSC mission.	1 2 3 4 5
2. My higher headquarters encourages us to provide feedback/comments to theater/Area of Operations BH/COSC policies.	1 2 3 4 5
3. We coordinate/integrate our BH/COSC activities with the Unit Ministry Teams in our Area of Operations.	1 2 3 4 5
4. We coordinate/integrate our BH/COSC activities with primary care medical personnel in the battalion aid stations/medical companies.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;
5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

D. COMBAT AND OPERATIONAL STRESS CONTROL AND BEHAVIORAL HEALTH SERVICES	
1. **During this deployment, how frequently did you:**	
a. Provide COSC outreach services?	1 2 3 4 5 6 7
b. Conduct educational classes?	1 2 3 4 5 6 7
c. Consult with unit leaders?	1 2 3 4 5 6 7
d. Conduct psychological debriefings (CED/CISD)?	1 2 3 4 5 6 7
e. Conduct systematic unit needs assessments?	1 2 3 4 5 6 7
f. Conduct Suicide Prevention Training?	1 2 3 4 5 6 7
g. Provide one-to-one BH counseling with Soldiers at their worksite?	1 2 3 4 5 6 7
h. Provide one-to-one COSC services with Soldiers at their worksite?	1 2 3 4 5 6 7
i. Provide one-to-one BH counseling with Soldiers at the BH/COSC unit location?	1 2 3 4 5 6 7
j. Provide one-to-one COSC services with Soldiers BH/COSC unit location?	1 2 3 4 5 6 7
2. Approximately how many Soldiers does your team support?	
3. How many locations (base camps/FOBs) does your BH/COSC team support?	
4. On average, how many hours does it take to convoy to the base camps you support (including preparation time)?	

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

E. SKILLS AND TRAINING	
1. I feel confident in my ability to:	
a. Use the COSC Workload and Activity Reporting System (COSC-WARS).	1 2 3 4 5
b. Help Soldiers adapt to the stressors of combat/deployment.	1 2 3 4 5
c. Evaluate and manage Soldiers with suicidal thoughts/behaviors.	1 2 3 4 5
d. Evaluate and treat Soldiers with substance abuse/dependence.	1 2 3 4 5
e. Evaluate and treat Combat and Operational Stress Reaction.	1 2 3 4 5
f. Evaluate and treat Acute Stress Disorder/PTSD.	1 2 3 4 5
g. Evaluate and treat victims of sexual assault.	1 2 3 4 5
h. Perform clinical evaluation and treatment of Iraqi civilians.	1 2 3 4 5
i. Perform clinical evaluation and treatment of detainees.	1 2 3 4 5
j. Perform clinical evaluation and treatment of Iraqi Security Force personnel.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

F. STIGMA AND BARRIERS TO CARE	
1. Commanders welcome back Soldiers who have received COSC services from my team.	1 2 3 4 5
2. Commanders welcome back Soldiers who have been assessed for suicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
3. Commanders welcome back Soldiers who have been assessed for homicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
4. Commanders welcome back Soldiers who have received other BH services from my team.	1 2 3 4 5
5. The medical leadership doesn't support BH/COSC outreach.	1 2 3 4 5
6. The supported units' leadership doesn't support BH/COSC activities.	1 2 3 4 5
7. There is inadequate transportation to conduct outreach activities.	1 2 3 4 5
8. There is inadequate communication between BH/COSC and supported units.	1 2 3 4 5
9. Soldiers feel uncomfortable talking to BH/COSC personnel about their problems.	1 2 3 4 5
10. BH/COSC personnel are unfamiliar with supported unit's leadership and Soldiers.	1 2 3 4 5
11. Traveling to supported units is too dangerous.	1 2 3 4 5
12. Arranging convoys to supported units is too difficult.	1 2 3 4 5
13. The inability to arrange convoys has led to mission cancellations.	1 2 3 4 5
14. BH/COSC personnel don't like to perform outreach services.	1 2 3 4 5
15. BH/COSC personnel aren't trained to conduct outreach services.	1 2 3 4 5
16. BH/COSC personnel are not available due to performing non-BH/COSC missions.	1 2 3 4 5
17. BH/COSC personnel don't think preventive outreach activities are effective.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Seldom; 3 = Frequently; 4 = Always

G. SOLDIER NEEDS	
1. **How do you assess the BH/COSC needs of the units you support?**	
a. Talk informally to the Soldiers	1 2 3 4
b. Conduct focus groups with Soldiers	1 2 3 4
c. Talk with the chaplains	1 2 3 4
d. Talk with the unit's commander	1 2 3 4
e. Talk with the unit's medical personnel	1 2 3 4
f. Use validated surveys/instruments	1 2 3 4
g. Use locally developed surveys/instruments	1 2 3 4
h. Develop a BH/COSC unit prevention and early intervention plan	1 2 3 4
i. Conduct Command Consultation	1 2 3 4

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

H. PERSONAL WELL-BEING	
1. My ability to do my behavioral health job is impaired by the stressors of deployment/combat.	1 2 3 4 5
2. My mental well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
3. My spiritual well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
4. Since this deployment, I have become less sensitive to the needs of the Soldiers I serve/support.	1 2 3 4 5
5. My ability to do my job is impaired by listening to the combat experiences of Soldiers I've talked with while performing my BH/COSC mission.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Very low; 2 = Low; 3 = High; 4 = Very high

6. **Please rate the following:**	
a. Your personal morale	1 2 3 4
b. Your energy level	1 2 3 4
c. Your level of burnout	1 2 3 4
d. Your motivation	1 2 3 4

The following equipment/supplies would have improved my team's ability to complete our BH/COSC mission:

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

I. PSYCHIATRIC MEDICATION (ONLY PSYCHIATRISTS/NURSE PRACTITIONNERS/PAs)	
1. The procedures for ordering/replenishing psychiatric medications in this theater/Area of Operations are clear.	1 2 3 4 5
2. In general, there has been adequate availability of appropriate psychiatric medications in the area of operations.	Yes / No
3. **There has been adequate availability of appropriate psychiatric medication at these levels of care:**	
a. Level I (Battalion Aid Station)	Yes / No
b. Level II (Forward Support Medical Company)	Yes / No
c. Level III (Combat Support Hospital)	Yes / No
4. What medications were needed by Soldiers during this deployment, but were not available to prescribe?	a)_____ b)_____ c)_____

Please provide any additional comments below.

Thank you for completing this survey!

APPENDIX 2

SUMMARY OF PRIMARY CARE (PC) SURVEY

INTRODUCTION

Primary care is frequently a BH referral source for Soldiers with MH problems. Some PC providers prescribe medication for mental disorders in addition to monitoring and refilling previously prescribed psychotropic medications. A part of the OIF-II Mental Health Advisory Team's (MHAT-II's) mission was to evaluate the working relationship between PC providers and BH personnel rendered in theater. The MHAT-II devised an anonymous questionnaire for primary medical care personnel. These personnel were doctors, physician assistants (PAs), nurses, and medics serving in BASs, FSMCs, and CSHs. Behavioral healthcare personnel is defined in this appendix as officer and enlisted personnel who provide BH services to Soldiers.

FINDINGS

Finding #1: Coordination is ongoing between PC personnel, BH personnel, and UMTs.

Over three quarters of the PC providers surveyed (78%) reported BH personnel had provided them information about where to refer Soldiers for MH problems, and 76% reported BH personnel had educated them on BH/COSC services available for Soldiers.

Forty-seven percent of the PC providers reported they coordinated/integrated their MH activities with UMTs, and 62% coordinated/integrated MH activities with BH personnel.

Finding #2: Primary care providers are helping Soldiers with MH problems, and they are referring Soldiers with MH problems to BH services.

Primary care providers were asked how frequently they provided services listed on the next page in Table 1. Twenty-four percent of the respondents reported helping Soldiers with MH problems either once or several times a week. Of this 24%, 14% referred Soldiers to BH personnel. While 78% of PC respondents indicated they had received information on where to refer Soldiers for MH services, 23% had not referred any Soldiers with MH problems to BH personnel; 8% had referred once; 22% had referred once every 2 to 3 months, and 47% had referred once a month or more.

Table 1: Provider Responses to Questions on Frequency of Service Delivery
The numbers in the columns below (1 through 7) are percentage rates of the response for each question in the left column. Below the chart is the definition key for each numeral 1-7.

PC Provider Provision of Mental Health Services	(% of Respondents)						
During this deployment, how frequently did you:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Help Soldiers for a mental health problem?	15	10	16	13	22	13	11
Conduct educational (stress management) classes?	68	11	10	6	3	1	1
Consult with unit leaders regarding mental health issues?	41	13	21	10	10	5	2
Refer Soldiers with mental health problems to the Chaplain?	40	14	22	10	10	3	2
Refer Soldiers with problems to the mental health personnel?	23	8	22	13	20	9	5

1 = Never; 2 = only once; 3 = Once every 2-3 months; 4 = Once a month; 5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

Finding #3: Almost three fourths of the PC providers feel confident in their ability to help Soldiers face MH issues, but are less confident to treat Soldiers with PTSD, substance abuse, or sexual assault.

While 73% of the PC providers reported they felt confident in helping Soldiers face MH issues during this deployment, 47% were confident in treating Soldiers with substance abuse/dependence; 58% were confident in treating Soldiers with combat and operational stress reaction (COSR); 64% were confident in treating acute stress disorder/PTSD; and 39% were confident in treating victims of sexual assault.

Finding #4: Primary care personnel do not believe many commanders will welcome back their Soldiers with BH problems.

Thirty-two percent of the PC providers believed commanders would welcome back Soldiers who received MH services, 22% agreed that commanders would welcome back Soldiers who displayed suicidal thoughts/behaviors, and 18% agreed that commanders would welcome back Soldiers with homicidal thoughts/behaviors.

Finding #5: Just over one third of PC personnel are experiencing burnout.

Thirty-seven percent of PC providers reported high burnout, 35% reported low motivation, and 35% reported low morale. Fifteen percent agreed that the stressors of deployment had impaired their medical job, and 14% indicated they had become less sensitive to the needs of Soldiers during this deployment.

BACKGROUND

Survey Methods and Procedures

The MHAT-II designed the PC survey. No standardized questions were used, though most of the questions were devised by consensus of the team members. Where possible, questions were standardized across the BH, PC, and UMT surveys. The questions ranged on a variety of topics of interest to the MHAT-II mission, such as standards of practice, provision and coordination of services, skills and training in relation to compliance and understanding of BH services, perceived stigma and barriers

to MH care, and general personal well-being. A copy of the instrument can be found at TAB A.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (MNC-I) operational theaters and administered surveys and conducted interviews with PC providers between 28 August and 30 September 2004. All PC providers who the MHAT-II contacted were asked to complete the survey regardless of their current work assignment or unit. Participants were briefed on the mission and informed that the survey was both anonymous and voluntary. All PC providers, which were asked to complete the survey, elected to participate.

Quality Control of Data

A total of 242 surveys were collected and the data entered into MS Access. A 10% QC was performed on the dataset to check for entry errors. Each and every one of the survey fields was read aloud by one staff member, while another staff member checked the hand-entered MS Access database.

Twenty-five (25) out of 242 surveys were quality checked. Each survey contained 68 fields, for a denominator of 1,700. Results revealed a total of 2 errors in 2 different fields. The error rate for all mistakes was 2/1,700 or .118%, below the accepted 0.2% error rate standard.

Study Sample

A convenience sample of 242 PC surveys was collected in 24 different locations around Iraq and Kuwait. (See Table 2 for professions represented.) Sixty-five percent of the surveyed respondents were age 30 or more. The rank distribution is as follows: junior enlisted Soldiers 20%, NCOs 22%, and officers 58%. Seventy-two percent of all surveyed were active component, 4% Army Reserve, and 23% National Guard. Ninety-five percent of the participants were Army, 4% were Navy, and 1% was Air Force. Seventy-two percent of the sample was male.

Participants had been deployed an average of 229 days (7.6 months) over the past 2 years, and 89% of those surveyed reported currently working in their PC job. Table 2 shows the types of professionals represented in the survey.

Table 2: AOCs and MOSs Represented in the PC Survey

Description	Number	Percent of Respondents
Medical Specialist 91W	85	35%
Physician Assistant	47	20%
Family Practice	28	15%
Nurse	10	4%
Emergency Medicine	9	4%
Flight Surgeon	7	3%
General Medical Officer	4	2%
Other (Internal Medicine, Surgeon, midwife, etc.)	51	21%

TAB A: Primary Care (PC) Survey

Primary Care (BAS/Medical) Personnel Survey

This survey is being conducted under the auspices of The Army Surgeon General's OIF Mental Health Advisory Team (MHAT). The purpose of this questionnaire is to gather data about the current mental well-being of Soldiers in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Definition: Mental health care is the clinical care of Soldiers with mental health problems or combat and operational stress reactions.

Today's Date: _____

Please circle the number of the category that best describes you.

A. DEMOGRAPHICS

Age:	*Gender:*	*Grade/Rank:*	*Primary Component:*
1 = 18-20	1 = Male	1 = E1–E4	1 = Active Component
2 = 21-24	2 = Female	2 = E5–E6	2 = Reserve (USAR)
3 = 25-29		3 = E7–E9	3 = National Guard
4 = 30-39		4 = O1–O3	4 = AGR
5 = 40 or older		5 = O4–O6	5 = Individual Ready Reserve (IRR)
		6 = WO1–WO5	

MOS/AOC:	*Which region best describes where you are currently serving?*	*For THIS deployment, please indicate the MONTH/YEAR you arrived in theater:*
1 = Emerg Med (61B)	1 = Northern Iraq (Mosul area)	
2 = Family Practice (61H)	2 = North East Iraq (Kirkuk area)	
3 = Flight Surgeon (61N)	3 = North Central Iraq (Tikrit/Balad area)	
4 = GMO (62B)	4 = Central Iraq (Baghdad area)	
5 = PA (65D)	5 = South Central Iraq (Karbala to Nasiriyah)	*How long (MONTHS) should a deployment last?*
6 = Nurse (66B)	6 = South Iraq (Basra area)	
7 = Med Specialist (91W)	7 = North Kuwait (Udairi, Virginia, etc.)	
8 = Other: _____	8 = South Kuwait (Doha, Arifjan, etc.)	
	9 = Other: _____	

How many TOTAL DAYS have you been deployed (combat or peacekeeping) in the **past 2 years**?	
How many MONTHS have you been assigned to your current unit?	
How many MONTHS has your current unit been deployed to Iraq/Kuwait?	
Are you **currently** working in my medical job?	Yes/No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

B. STANDARDS	
1. The standards of medical care in this theater/Area of Operations are clear.	1 2 3 4 5
2. The standards of mental health care in this theater/Area of Operations are clear.	1 2 3 4 5
3. The standards for clinical documentation in this theater/Area of Operations are clear.	1 2 3 4 5
4. The standards for records management in this theater/Area of Operations are clear.	1 2 3 4 5
5. The standards for transfer of clinical mental health information between levels of care in this theater/Area of Operations are clear.	1 2 3 4 5

C. COORDINATION	
1. We coordinate/integrate our mental health activities with the Unit Ministry Teams in our Area of Operations.	1 2 3 4 5
2. We coordinate/integrate our mental health activities with mental health personnel in our Area of Operations.	1 2 3 4 5
3. Mental health personnel have provided us information about where to refer Soldiers for mental health problems.	1 2 3 4 5
4. Mental health personnel have provided us information about the services they provide to Soldiers.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;
5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

D. COMBAT AND OPERATIONAL STRESS CONTROL AND MENTAL HEALTH SERVICES	
1. **During this deployment, how frequently did you:**	
a. Help Soldiers for a mental health problem?	1 2 3 4 5 6 7
b. Conduct educational (stress management) classes?	1 2 3 4 5 6 7
c. Consult with unit leaders regarding mental health issues?	1 2 3 4 5 6 7
d. Refer Soldiers with mental health problems to the Chaplain?	1 2 3 4 5 6 7
e. Refer Soldiers with problems to the mental health personnel?	1 2 3 4 5 6 7
2. Approximately how many Soldiers does your team support?	

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

E. SKILLS AND TRAINING	
1. **I feel confident in my ability to:**	
a. Help Soldiers face mental health issues during the deployment.	1 2 3 4 5
b. Evaluate and treat Soldiers with substance abuse/dependence.	1 2 3 4 5
c. Evaluate and treat Combat and Operational Stress Reaction.	1 2 3 4 5
d. Help Soldiers face BH/COSC issues during the deployment.	1 2 3 4 5
e. Evaluate and treat Acute Stress Disorder/Posttraumatic Stress Disorder.	1 2 3 4 5
f. Evaluate and treat victims of sexual assault.	1 2 3 4 5
g. Perform clinical evaluation and treatment of Iraqi civilians.	1 2 3 4 5
h. Perform clinical evaluation and treatment of detainees.	1 2 3 4 5
i. Perform clinical evaluation and treatment of Iraqi Security Force personnel.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

F. STIGMA AND BARRIERS TO MENTAL HEALTH CARE	
1. Commanders welcome back Soldiers who have received mental health services from my team.	1 2 3 4 5
2. Commanders welcome back Soldiers who have been assessed for suicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
3. Commanders welcome back Soldiers who have been assessed for homicidal thoughts/behaviors and returned to duty.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

G. PERSONAL WELL-BEING	
1. My ability to do my medical job is impaired by the stressors of deployment/combat.	1 2 3 4 5
2. My mental well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
3. My spiritual well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
4. Since this deployment, I have become less sensitive to the needs of the Soldiers I serve/support.	1 2 3 4 5
5. My ability to do my job is impaired by listening to the combat experiences of Soldiers I've talked with while performing my BH/COSC mission.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Very low; 2 = Low; 3 = High; 4 = Very high

6. **Please rate the following:**	
a. Your personal morale	1 2 3 4
b. Your energy level	1 2 3 4
c. Your level of burnout	1 2 3 4
d. Your motivation	1 2 3 4

The following equipment/supplies would have improved my team's ability to complete our medical mission:

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

H. PSYCHIATRIC MEDICATION (ONLY PHYSICIANS/NURSE PRACTITIONERS/PAs)	
1. The procedures for ordering/replenishing psychiatric medications in this theater/Area of Operations are clear.	1 2 3 4 5
2. In general, there has been adequate availability of appropriate psychiatric medications in the area of operations.	Yes / No
3. **There has been adequate availability of appropriate psychiatric medication at these levels of care:**	
a. Level I (Battalion Aid Station)	Yes/No
b. Level II (Forward Support Medical Company)	Yes/No
c. Level III (Combat Support Hospital)	Yes/No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;
5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

4. **During this deployment, how frequently did you prescribe medication for:**	
a. Sleep problems?	1 2 3 4 5 6 7
b. Depression?	1 2 3 4 5 6 7
c. Anxiety?	1 2 3 4 5 6 7
5. What medications did Soldiers need during this deployment, but were not available to prescribe?	a)_____ b)_____ c)_____

Please provide any additional comments below.

Thank you for completing this survey!

APPENDIX 3

SUMMARY OF UNIT MINISTRY TEAM (UMT) SURVEY

INTRODUCTION

The Unit Ministry Team (UMT) survey was administered to gather data regarding the UMT's pastoral support of deployed troops, how well they interface with BH assets during OIF-II, and to provide recommendations from the identified findings. The UMT personnel are defined as both chaplains and chaplain assistants and are included in all analyses below, except where otherwise noted.

Prior to their deployment to theater, the MHAT members constructed the survey. The UMT survey from last year's MHAT-I focused on UMTs and suicide prevention. This survey focused on combat stress and UMT's interface with the BH system in theater. Standardized questions were used in conjunction with BH and PC formats and devised by consensus of the team members. The questions covered a variety of topics of interest to the MHAT mission, such as coordination with BH assets for CSC, UMT religious and pastoral care activities, skills and training, perceived stigma and barriers to care, Soldiers' needs, personal well-being of the UMT member, and what UMT members perceive as the major issues impacting Soldiers. Space was provided for participants to make comment regarding equipment needed, and any additional comments regarding the deployment.

FINDINGS

Finding #1: Most UMT personnel are providing suicide prevention training.

Eighty-five percent of UMT personnel (91% of chaplains) report that they have conducted suicide prevention training at least once during the deployment. Just over half (51%) conduct suicide prevention training monthly or more often.

Finding #2: Most chaplains are conducting critical event debriefing (CED) sessions.

Seventy-six percent report conducting at least one CED/Critical Incident Stress Debriefing (CISD) session during the deployment; 25% conduct CED/CISDs monthly or more often.

Finding #3: Unit ministry team personnel regularly identify Soldiers at risk for battle fatigue.

Twenty-five percent of UMT personnel (82% of chaplains) report having identified at least one Soldier at risk for battle fatigue, and nearly half (49%) report identifying a Soldier once a month or more often. Fifteen percent identify a Soldier at risk once a week or more often. (Note: Army Chaplain Corps doctrine still uses the term "battle

fatigue" for what joint medical doctrine now refers to as "combat and operational stress reactions (COSRs).")

Finding #4: Unit ministry team personnel report receiving good coordination from BH personnel. Most chaplains report coordinating/integrating their UMT religious activities with the BH/COSC team(s) and PC personnel in their Area of Operations (AO).

Eighty-three percent of UMT personnel agreed that BH personnel had provided them with information about MH services that were provided, and where to refer soldiers with MH problems. Fifty-eight percent of UMT personnel (61% of the chaplains) acknowledged coordinating/integrating their UMT activities with BH personnel. Sixty-three percent (75% of chaplains) coordinated/integrated services with PC personnel in their AO.

Finding #5: Most UMT personnel report high morale, energy, and motivation. Most also report that their mental and spiritual well-being and their ability to do their job have not been impaired by deployment/combat stressors. However, there were some UMT personnel who reported problems with burnout.

A great majority of UMT personnel indicated high levels of morale, energy, and motivation. Seventy-six percent reported that morale was high or very high. Seventy-two percent indicated that their energy level was either high or very high. Eighty-five percent reported high or very high levels of motivation. Sixty-two percent reported that their level of burnout was low or very low.

Most UMT personnel reported that their mental well-being was not adversely affected by their role as providers. Sixty-nine percent of the UMTs surveyed disagreed or strongly disagreed that their mental well-being was adversely affected by listening to the combat experiences of Soldiers. Further, 79% of UMT personnel surveyed disagreed or strongly disagreed that the stressors of deployment and combat impair their job.

Although most are doing well, 16% of UMT personnel agreed or strongly agreed that the stressors of the deployment and combat impaired their job. They also reported low or very low personal energy (28%), personal motivation (23%), personal morale (18%), and high or very high personal burnout (33%). Some also reported having their mental (13%) or spiritual (15%) well-being adversely affected by combat or deployment stressors.

RECOMMENDATIONS

Recommendation #1: Ensure UMT personnel understand COSC principles.

Field Manual (FM) 1-05 states that "the Unit Ministry Team works closely with the unit's leaders and medical personnel to care for battle fatigue cases through religious support and comfort." Survey data revealed that UMT personnel regularly identify Soldiers with combat and operational stress and that they regularly provide CED/CISDs within their units. Working together, BH and UMT personnel can provide reinforced vigilance and intervention to Soldiers who might not otherwise seek or receive care.

Recommendation #2: Research burnout and develop/implement a program to prevent or reduce it.

Although the vast majority of chaplains and chaplain assistants are doing very well, a small, but significant portion (15-30%) are experiencing combat/deployment-induced problems that may affect their ability to care for Soldiers. Further research into the causes, effects, and mitigating factors involved in the burnout process is needed. Once these factors are better understood, prevention and/or intervention programs should be devised to assist UMT personnel.

BACKGROUND

Procedures

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (MNC-I) operational theaters, and administered surveys to UMT personnel between 29 August and 8 October 2004. Surveys were administered to combat, combat support, and combat service support units. The UMTs were surveyed as part of these units that the MHAT surveyed.

The MHAT personnel administered the surveys. All participants were briefed on the mission of the MHAT and informed that the survey was both anonymous and voluntary. All UMT personnel asked to complete the survey did so.

Quality Control of Data

Data collected from the surveys were entered into a MS Access database. A 10% quality check was performed on the first 150 surveys entered into the dataset to check for entry errors. Each and every one of the survey fields was read aloud by one staff member, while another staff member checked the hand-entered MS Access database. Fifteen out of 150 surveys were quality checked; 80 fields in each survey. Results revealed a total of 9 errors among the 1200 (80 x 15) fields checked. The error rate for all hand-entry mistakes was 0.75%.

Comparison of Data to OIF-I Mental Health Advisory Team

Due to changes in the survey, The OIF-I and OIF-II Unit Ministry Team surveys only have one question in common. The focus of the OIF-I Unit Ministry Team survey was suicide prevention, while the OIF-II UMT survey covered a wider variety of topics.

Study Sample

A convenience sample of 86 Army and 3 Air Force chaplains, and 74 Army, 2 Navy, and 4 Air Force chaplain assistants completed the survey between 29 August and 8 October 2004 at 21 locations in Kuwait and Iraq. Because UMT members were also canvassed during routine UMT training meetings in both Kuwait and Iraq, more than 21 locations are actually represented. More than 70% of the chaplains and chaplain assistants in Iraq were surveyed.

Of the commissioned chaplains, 46% were field grade officers, and of the enlisted chaplain assistants, 51% were NCOs. Of all the respondents, 57% were Active Component, 27% were National Guard, and 15% were Army Reserve Soldiers. Seventy-three percent of the chaplains were age 40 or older, while 77% of the chaplain assistants were under age 40. Two chaplains and seven chaplain assistants were female. The UMT personnel had been deployed a median 240 days in the last 2 years (may include other deployments than the current one), and 99% reported that they were performing UMT duties while in theater.

Table 1 shows the types of units the respondents supported in theater. Table 2 is a breakdown by percentage of Section C of the UMT Religious Activities that responders reported.

Table 1: Types of Units the UMT Respondents Supported

Description	Percent of Respondents
Combat Arms Units	36%
Combat Support Units	27%
Combat Service Support Units	21%
Medical	6%
Unknown or Unmarked	10%

Table 2: The UMT Religious Activities that Respondents Reported

The numbers in the columns below (1 through 7) are percentage rates of the response for each question a. through o. from Section C of the UMT survey. Below the chart is the definition key for each numeral 1-7.

BH/COSC Services	**(% of Respondents)**						
1. **During this deployment, how frequently did you:**	1	2	3	4	5	6	7
a. Provide ministry of presence?	2	1	2	4	2	6	83
b. Conduct suicide prevention training?	15	12	22	10	17	15	9
c. Conduct religious services?	6	2	1	2	4	28	58
d. Conduct memorial services?	38	22	27	6	3	2	2
e. Identify Soldiers at risk for battle fatigue?	25	8	19	16	17	8	7
f. Provide crisis intervention management?	18	10	19	17	15	12	9
g. Conduct educational classes (stress management, etc.)?	31	12	27	9	11	7	4
h. Consult with unit leaders?	4	1	4	6	12	23	51
i. Conduct psychological debriefings (CED/CISD)?	36	12	25	13	7	3	3
j. Conduct systematic unit religious needs assessments?	26	25	18	14	9	4	5
k. Conduct grief facilitation and hope counseling?	27	5	16	11	17	13	11
l. Reinforce Soldiers' faith and hope?	3	1	2	5	8	17	64
m. Provide Soldiers opportunities to discuss their combat experiences?	6	4	6	7	14	19	43
n. Provide one-to-one pastoral counseling with Soldiers at their worksite.	14	2	2	5	7	16	54
o. Provide one-to-one pastoral counseling with Soldiers at the UMT worksite?	14	1	2	5	8	12	57

1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month; 5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

TAB A: Unit Ministry Team (UMT) Survey

Unit Ministry Team (UMT)
Personnel Survey

This survey is being conducted under the auspices of The Army Surgeon General's OIF Mental Health Advisory Team (MHAT). The purpose of this questionnaire is to gather data about the current mental/spiritual well-being of Soldiers and chaplains in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Definitions: In this survey, Combat and Operational Stress Control (COSC) is used synonymously with preventive, educational and outreach services, and the management of combat and operational stress reactions. Behavioral Health (BH) is used synonymously with clinical care for behavioral health disorders (i.e., evaluation and treatment).

Today's Date: _____

Please circle the number of the category that best describes you.

A. DEMOGRAPHICS

Age:	***Gender:***	***Grade/Rank:***	***Primary Component:***
1 = 18-20	1 = Male	1 = E1–E4	1 = Active Component
2 = 21-24	2 = Female	2 = E5–E6	2 = Reserve (USAR)
3 = 25-29		3 = E7–E9	3 = National Guard
4 = 30-39		4 = O1–O3	4 = AGR
5 = 40 or older		5 = O4–O6	5 = Individual Ready Reserve (IRR)
		6 = WO1–WO5	

MOS/AOC:	***Which region best describes where you are currently serving?***	***For THIS deployment, please indicate the MONTH/YEAR you arrived in theater:***
1 = Chaplain (56A)	1 = Northern Iraq (Mosul area)	
2 = Chaplain Assist. (56M)	2 = North East Iraq (Kirkuk area)	
3 = Other: _____	3 = North Central Iraq (Tikrit/Balad area)	
	4 = Central Iraq (Baghdad area)	
What type of unit do you support?	5 = South Central Iraq (Karbala to Nasiriyah)	***How long (MONTHS) should a deployment last?***
1 = Combat (IN, AR, FA)	6 = South Iraq (Basra area)	
2 = Combat Support	7 = North Kuwait (Udairi, Virginia, etc.)	
3 = Combat Svc Support	8 = South Kuwait (Doha, Arifjan, etc.)	
4 = Medical	9 = Other: _____	
5 = Other: _____		

How many TOTAL DAYS have you been deployed (combat or peacekeeping) in the **past 2 years**?	
How many MONTHS have you been assigned to your current unit?	
How many MONTHS has your current unit been deployed to Iraq/Kuwait?	
Are you **currently** working in my UMT job?	Yes/No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

B. COORDINATION	
1. My command provides us with the resources required to conduct our UMT religious activities.	1 2 3 4 5
2. My chaplain chain of command provides us with the resources required to conduct our UMT religious activities.	1 2 3 4 5
3. We coordinate/integrate our UMT religious activities with the BH/COSC team(s) in our Area of Operations (AO).	1 2 3 4 5
4. We coordinate/integrate our UMT religious activities with primary care medical personnel in the battalion aid station(s)/medical company(s) in our AO.	1 2 3 4 5
5. Mental health personnel have provided us information about where to refer Soldiers for mental health problems.	1 2 3 4 5
6. Mental health personnel have provided us information about the services they provide to Soldiers.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;
5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

C. UMT RELIGIOUS ACTIVITIES	
1. **During this deployment, how frequently did you:**	
a. Provide ministry of presence?	1 2 3 4 5 6 7
b. Conduct suicide prevention training?	1 2 3 4 5 6 7
c. Conduct religious services?	1 2 3 4 5 6 7
d. Conduct memorial services?	1 2 3 4 5 6 7
e. Identify Soldiers at risk for battle fatigue?	1 2 3 4 5 6 7
f. Provide crisis intervention management?	1 2 3 4 5 6 7
g. Conduct educational classes (stress management, etc.)?	1 2 3 4 5 6 7
h. Consult with unit leaders?	1 2 3 4 5 6 7
i. Conduct psychological debriefings (CED/CISD)?	1 2 3 4 5 6 7
j. Conduct systematic unit religious needs assessments?	1 2 3 4 5 6 7
k. Conduct grief facilitation and hope counseling?	1 2 3 4 5 6 7
l. Reinforce Soldiers' faith and hope?	1 2 3 4 5 6 7
m. Provide Soldiers opportunities to discuss their combat experiences?	1 2 3 4 5 6 7
n. Provide one-to-one pastoral counseling with Soldiers at their worksite?	1 2 3 4 5 6 7
o. Provide one-to-one pastoral counseling with Soldiers at the UMT worksite?	1 2 3 4 5 6 7
2. Approximately how many Soldiers does your team support?	
3. How many locations (base camps/FOBs) does your UMT support?	
4. On average, how many hours does it take to convoy to the base camps you support (including preparation time)?	

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

D. SKILLS AND TRAINING	
1. **I feel confident in my ability to:**	
a. Conduct pastoral counseling.	1 2 3 4 5
b. Conduct suicide prevention classes/training for Soldiers.	1 2 3 4 5
c. Identify and assist Soldiers with suicidal thoughts/behaviors.	1 2 3 4 5
d. Help Soldiers adapt to the stressors of combat/deployment.	1 2 3 4 5
e. Identify Soldiers with substance abuse/dependence.	1 2 3 4 5
f. Assist Soldiers with sexual harassment issues.	1 2 3 4 5
g. Identify Soldiers with Combat and Operational Stress Reactions.	1 2 3 4 5
h. Perform clinical evaluation and treatment of detainees.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

E. STIGMA AND BARRIERS TO CARE	
1. Commanders welcome back Soldiers who have received mental health services.	1 2 3 4 5
2. Commanders welcome back Soldiers who have been assessed for suicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
3. Commanders welcome back Soldiers who have been assessed for homicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
4. The leadership doesn't support pastoral counseling activities.	1 2 3 4 5
5. There is inadequate transportation to conduct UMT religious activities.	1 2 3 4 5
6. Soldiers feel uncomfortable talking to UMT personnel about their problems.	1 2 3 4 5
7. Traveling to supported units is too dangerous.	1 2 3 4 5
8. Arranging convoys to supported units is too difficult.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Seldom; 3 = Frequently; 4 = Always

F. SOLDIER NEEDS	
1. **How do you assess the religious/spiritual needs of the units you support?**	
a. Talk informally to the Soldiers	1 2 3 4
b. Conduct focus groups with Soldiers	1 2 3 4
c. Talk with the BH/COSC personnel	1 2 3 4
d. Talk with the unit's commander	1 2 3 4
e. Talk with the unit's medical personnel	1 2 3 4
f. Use validated surveys/instruments	1 2 3 4
g. Use locally developed surveys/instruments	1 2 3 4
h. Develop a religious support plan	1 2 3 4

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

G. PERSONAL WELL-BEING	
1. My ability to do my UMT job is impaired by the stressors of deployment/combat.	1 2 3 4 5
2. My mental well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
3. My spiritual well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
4. Since this deployment, I have become less sensitive to the religious/spiritual needs of the Soldiers I serve/support.	1 2 3 4 5
5. My ability to do my job is impaired by listening to the combat experiences of Soldiers I've talked with while performing my BH/COSC mission.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Very low; 2 = Low; 3 = High; 4 = Very high

6. **Please rate the following:**	
a. Your personal morale	1 2 3 4
b. Your energy level	1 2 3 4
c. Your level of burnout	1 2 3 4
d. Your motivation	1 2 3 4

The following equipment/supplies would have improved my team's ability to complete our UMT mission:

Please provide any additional comments on the back.

Thank you for completing this survey!

APPENDIX 4

SUMMARY OF BEHAVIORAL HEALTH INTERVIEWS

INTRODUCTION

Face-to-face interviews with BH personnel in Kuwait and Iraq were conducted to obtain level of perspectives on the delivery, resources, and problems encountered providing MH/BH care in a combat operational theater. All BH specialties were represented and were the following: Psychiatrists, psychologists, social workers, occupational therapists, psychiatric clinical nurse specialists/psychiatric nurses, MH specialists, and OT assistants.

APPROACH

Face-to-Face Interviews

Members of the MHAT conducted all interviews on an interview schedule (see TAB A). Forty-two individual or group interviews were conducted at 12 different locations throughout Kuwait and Iraq with the following composition:

RANK	PARTICIPANTS	% OF TOTAL
Field Grade	20	24%
Company Grade	20	24%
NCO	15	18%
Junior Enlisted	27	34%
TOTAL	**82**	**100%**

Themes/Questions

Prior to all interviews, key themes and specific questions were determined that every MHAT interviewer would attempt to address. All individuals were asked the same questions. Interview questions were: (1) What can you tell us about your experience that we didn't ask on the survey? (2) What challenges or obstacles to providing care have you faced during the deployment? (3) What additional training would you benefit from prior to deployment, if any?

Procedures

All interviews began with a member of the MHAT introducing himself/herself and describing the purpose and objective of the interview. Confidentiality and anonymity were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the interviewees' were recorded. Interviews lasted approximately 20 to 60 minutes.

RESULTS

Behavioral Health Personnel in Kuwait

Participants were four enlisted and eight officers at three separate unit locations in Kuwait. Several issues surfaced that were not asked on the BH survey that were discussed during the interview:

- *Behavioral Health System Concerns:*

1. There were limited drug and alcohol treatment programs, but Alcoholics Anonymous (AA) was available for Soldiers.

2. Some BH personnel were assigned to do other jobs, such as psychiatric registered nurses (RNs) who were asked to work in Medicine/Surgery areas.

3. It would have been helpful to know prior to deployment what was available, and what was needed for clinical practice in theater such as reference books, because procuring equipment in theater was challenging.

4. There were limited computers and lack of private space to work with Soldiers.

5. Getting out to other FOBs was challenging due to poor roadways.

6. The concept of operations for the United States Air Force (USAF) teams was not defined regarding how much should be Army-type CSC prevention versus clinical care outreach or stationary clinic.

7. The Navy team defined its mission as solely clinical care, staffed clinics, and established an "Intensified Outpatient Program" on the Navy's model in a minimally furnished building, but then dropped the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and lumped the admissions into "combat stress reactions" and "operational stress reactions," as in Army restoration programs.

8. There was confusion about the concept of operations with an Army medical headquarters directing two USAF and one Navy team, but not defining it as a joint command.

9. It was unclear to the Air Force BH personnel what the support relationship was; they solicited essential equipment from the U.S. Air Force EMED (hospital) with whom they had no defined relationship.

- *Suggested additional training that would benefit staff before deployment included:*

1. Drug and Alcohol Program Adviser (DAPA)/Substance Abuse Rehabilitation Program (SARP) training and perhaps Adams classes (alcohol/substance abuse awareness) for all staff such as the Navy is doing presently.

2. Cross-training service members from sister services on cultural issues, etc.

3. Critical Incident Stress Debriefing, Cognitive Behavioral Therapy, PTSD treatment training, and Sexual Assault Victim Intervention training.

Behavioral Health Personnel in Iraq

Thirty-two officers and 38 enlisted BH personnel at ten different locations throughout Iraq shared common concerns and experiences that were not captured on the BH survey. Many of the themes below were reported more than once, but are listed only once for this report.

- *The Behavioral Health System:*

1. Overall, felt well prepared to perform the mission. The mutual support of providers helped tremendously.

2. Difficulty fitting in when cross-leveled to an established unit. Integrating 75% of personnel who were cross-leveled to a unit was challenging, especially with leadership and chain of command.

3. Challenges for teams to get life support when they arrive at a FOB. Need prior communication with the Area Support Groups (ASGs) to find out what units are in the FOBs and their point of contact (POC). It is best to have the CSC Detachment (or teams) collocate with an ASG and cover its area of operations. Teams may have to be tasked out and attached under operational control for support. They should send an advanced liaison to set it up. Behavioral health personnel need further training in operational details (like fragmentary orders (FRAGOs), etc.). Better coordination between outgoing and incoming BH personnel would also smooth transitions.

4. Differing tour lengths (3, 6, and 12 months) between the different services hurt BH morale. The rapid turnover of psychiatrists (60Ws) disrupted continuity of care and decreased morale of the CSC team. High personnel tempo (PERSTEMPO) may lead to reduced retention for some BH personnel—particularly among early- and mid-career personnel.

5. A road map for deployment for U.S. Army Reserves (USAR) and Army National Guard (ARNG) Soldiers would be helpful.

6. Separate (National Guard) brigades are not authorized a BH officer, and one is needed.

7. The limited range of types of patients during deployment may cause providers to lose skills. Stop-loss has been tough on professionals, especially since some professionals rotate out in 90 to 180 days.

8. Each battalion should have specified BH staff who support them as a means to assist with building relationships with the medical and UMT personnel assigned to each battalion.

9. Operating forward is essential to improving soldier access and lower stigma. Chaplain support is essential to effectiveness; developing rapport with the chaplain has really helped with BH mission accomplishment.

10. In some cases, enlisted MH personnel (91Xs) were needed to contribute to the BH mission; therefore, they were pulled away from BH work.

11. Personal stressors (long hours with no time off, trying to please everyone, time away from family, weather and heat, transition from medical center (MEDCEN) to TO&E unit) take a toll on BH personnel.

12. Tighten pre-deployment screening, for medical illness as well as mental/behavioral ones. Civilian PAs did most of the screening; they need more information about the Theater—its limited resources, the harsh environment, the consequences of decompensation, and options for deferring deployment. It would be best to assign providers who have been here to do redeployment screening. Consider pre-deployment psychological testing of Soldiers who are already on psychotropic meds in the soldier readiness processing (SRP) before going on to other screening to decrease inappropriate deployment.

- *Administrative Issues:*

1. Some personnel actions (promotions, etc.) are being held up because BH personnel were not correctly told to bring their personnel (201) files with them to theater.

2. Lack of replacements for the unit members sent home degrades the mission capability of the unit.

3. Training on useful military forms, unit movement, supplies, Form Flow, lessons learned, and standing operating procedures (SOPs) on administrative/logistics coordination in a "Smart Book" would be very helpful. Also knowing the administrative skills of the S1, S2, and S3 would be helpful. Training for writing an Operational Needs Assessment (with examples) and conducting one's own unit Needs Assessment would be helpful before deploying. Know how to do command referrals/evaluations,

regulations (format, requirements on the electronic version), and when to do clinical documentation vs. COSR documentation before you deploy.

4. Be prepared to use the COSC-WARS before deploying.

5. Identify and resolve credentialing early (best before activation/mobilization).

6. Completing the continuing medical education requirement while in Theater is hard to do; this is a reason for having 6-month rotations instead of 1-year rotations. Internet education could meet some needs.

7. Have more on CSC in Command & General Staff College, Officer Candidate School (OCS), etc.

8. Have references available for military BH law, ethics, and regulations.

- *Logistical/Equipment Issues:*

1. Very difficult to communicate within own unit as well as with other units. For example, one unit reported having only one single-channel ground and airborne radio systems (SINCGARS) radio, but having teams at 18 locations all over Iraq. The digital nonsecure voice terminal (DNVT) phones were often down, too. Some reported no computer equipment and lack of supplies. One unit acquired Thuriya cell phones by negotiation and Iraqi commercial cell phones by purchase, in order to maintain communications and to accomplish the mission. Some unit members received training in the use and maintenance of the DNVT and other Army communication, which enabled some successful troubleshooting.

2. Limited space for work and lack of privacy in the workspace for working with Soldiers

3. Psychological testing kit materials were outdated; updated ones are needed.

4. More training was needed on how to obtain logistical support from the line units.

- *Training Needs:*

1. 1. Refresher training on COSC, critical incident stress management (CISM) training, mini-course for 60Ws with a CSC perspective. Teach area of concentration specifics so all staff can know each other's strengths.

2. More training for 91Xs before deployment. The 91Xs could use more clinical training since many do not work in the field in their civilian life, e.g. training on interviewing and counseling. More training on personality disorders would be helpful to the staff. One 91X reported: "My AIT had no clinical experience, and I went straight to

my division just before deployment. They let me work a little in Community MH to get my skill level up."

3. Provide clinical training for USAR and National Guard BH personnel on drill weekends with real patients (e.g. at VA, Univ. Hospital, etc.).

4. Lack of skills in dealing with real medical emergencies by many BH staff. The 91X Soldiers should also complete 91W training to prepare for combat emergencies.

5. Training on how to interact with commands; Iraq country skills. Training on awards, efficiency reports, etc.

6. Reduce unnecessary training in 91X school and devote more training time on crisis intervention, suicide prevention/intervention, COSC, anger management, battle fatigue, life saving skills, CED training, home front issues, solutions to soldier based issues, and family crisis intervention.

7. Training in pharmacological management of Soldiers in theater

8. Training in managing vicarious trauma, burnout, and compassion fatigue. Also training in team building and conflict negotiation. Important to set up help for helpers at each location—providing an outlet for providers. Awareness and buddy aid for providers. Behavioral health personnel should not skip BH-topic briefings on the assumption that they know it.

9. Updated training on the VA/DoD clinical guidelines for PTSD

10. For military training, more field and combat environment training, and more training on soldiering skills such as: convoy techniques (convoy operations training much more realistic in Kuwait than at the mobilization site in CONUS), survival skills training; battle drills; command liaison/consultation etiquette; and how to get life support in theater

TAB A: Behavioral Health Interview/Focus Group Schedule

Behavioral Health/COSC Personnel Interview/Focus Groups

"This information is anonymous and will not be linked to your unit. The information will be combined with that of other units to reflect the nature of BH/COSC units in OIF-II."

Interviewer:

Notes Taken By (if other than interviewer):

Date:

Location:

Number in Group:

Group Type (Circle): Jr. Enlisted (E1-E4) NCOs (E-5 +) Officers Mixed

Ranks: ____ E1-E4; ____ E5-E6; ____ E7-E9; ____ O1-O3; ____O4-O6

Gender: ____ Males; ____ Females

Unit:

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1. What can you tell us about your experience that we didn't ask on the surveys?

2. What challenges have you faced during this deployment?

3. What additional training would you benefit from prior to deployment, if any?

APPENDIX 5

DISTRIBUTION OF BEHAVIORAL HEALTH SERVICES

INTRODUCTION

Assessment of staffing and distribution were key parts of the OIF-II Mental Health Advisory Team's (MHAT's) mission to evaluate the BH care in the OIF Theater. Three particular questions that were addressed were: (1) Are there enough BH personnel in theater to successfully accomplish the BH mission? (2) Are the BH personnel/units adequately distributed throughout theater to successfully execute the BH service mission? (3) What are appropriate levels of BH staffing for future similar deployments?

In order to answer these three questions, the MHAT generated a layout of the BH resources in theater (as of 1 October 2004) and examined a number of possible methods for estimating the need for and positioning of BH personnel.

The data gathered for this analysis came from reports, maps, and interviews with BH personnel, cartographers, and division/corps personnel officers. The validity of parts of this analysis is time limited due to the constant changing battlefield and concomitant shifts in personnel. For convenience, 1 October 2004 was chosen as a cross-sectional target date. Changes made after 1 October 2004 are not reflected in this analysis. Although there are no data to support this, a key assumption is that on-site BH personnel will help to reduce barriers to BH care.

This analysis only includes Army Soldier populations, Army BH personnel, and those Navy and Air Force BH personnel who are primarily serving Army Soldiers. Special Forces personnel and FOBs with a population of less than 25 U.S. Army Soldiers were also excluded from this analysis.

FINDINGS

Finding #1: The ratio of BH personnel to Soldiers is greater this year (OIF-II) than last year (OIF-I).

Last year (OIF-I), 163 BH personnel (psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, enlisted MH specialists, and OT technicians) provided services for an estimated 138,000 Soldiers in Kuwait and Iraq in September 2003. The overall ratio of BH personnel to Soldiers was 1/851. As of 1 October 2004, 232 BH personnel (see Table 1) are providing services to an estimated 94,500 Soldiers in Kuwait and Iraq, for a ratio of 1/407—a ratio over twice that of OIF-I. Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage.

In Kuwait, Navy and Air Force personnel were providing most BH coverage. Other than a few Army staff members (b)(2)-2 the bulk of the primary medical care was performed by Navy personnel, and all of the BH prevention and early intervention was performed by (b)(2) Air Force Operational Stress Teams (OSTs) (See Tables 2 and 3). Based on Soldier population, there are fewer BH personnel in Kuwait (1/656 overall) than in Iraq (1/388) where the need is greater due to operational stressors.

Finding #2: Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I.

The OIF-II ratios varied from 1/160 to 1/888 (with a standard deviation of 227). The OIF-I ratio of BH personnel to Soldiers varied from zero (no BH personnel) to 1/3,292 by region (with a standard deviation of 1,038).

Finding #3: Forward operating bases with higher Soldier populations tend to have more on-site BH personnel. There were some FOBs in all size categories without on-site BH personnel located on them. These FOBs may receive BH services from neighboring FOBs.

Seventy-six percent (76%) of Soldiers live on FOBs where BH personnel are collocated. (NOTE: For simplicity, "FOB" includes base camps, logistical support areas, ranges, etc., in Kuwait and Iraq). In general, as the size of the FOB population decreased, the number of BH personnel to Soldiers also decreased, and the variance in the distribution of BH personnel within each size category increased (see Table 4). Almost all FOBs with more than 1,000 Soldiers had a BH professional on site. One FOB in Iraq with over 3,000 Soldiers and two FOBs with 1,000-3,000 Soldiers had no on-site BH personnel.

The MHAT visits to, and interviews with, PC and UMT personnel at some sites without on-site BH personnel indicated that BH personnel were not regularly visiting some of these FOBs. However, data from the Soldier Health and Well-being Survey showed that Soldiers on smaller FOBs reported nearly identical rates of utilization of MH services as Soldiers on larger FOBs. On FOBs with Soldier populations less than or equal to 1,000 in size, 11% of Soldiers saw a MH or CSC professional during the deployment, compared with 9% of Soldiers on FOBs that had a population of 1,001-3,000, and 11% on FOBs over 3,000.
Finding #4: Psychiatrists, psychiatric nurses, and occupational therapists—who specialize in medical management and restoration/reconstitution services—were generally located at larger FOBs, while social workers and clinical psychologists were located farther forward (smaller FOBs) to provide more outreach services.

Table 5 shows the distribution of BH specialties by FOB size.

Finding #5: There is adequate BH holding capacity in theater.

On an emergent basis, "holding capacity" is available at CSC units, medical companies, and at CSHs. The CSC units have the capability to set up many more Level II cots for stress and psychiatric casualties if needed. Each of the CSH slices are able to admit Soldiers with BH problems; however, none of the Army CSH slices in theater is staffed to host a psychiatric treatment ward which is appropriate given the current theater evacuation policy (see Table 6).

Theater BH personnel interviewed indicated that, in general, a Soldier deemed to require an inpatient level of care is only held long enough to be stabilized, evaluated, and prepared for evacuation out of theater. All of the CSHs have partnered with CSC units to provide BH treatment services (see Finding #6 below).

Finding #6: The CSC restoration programs are located near CSH slices and often share resources.

Like last year's MHAT, the MHAT this year noted that the four CSC restoration programs are located on the same FOBs as the CSHs (see Table 7). Collocating the CSC fitness teams with the CSHs has been implemented in various ways, often synergistically. The [b)(2)-2] provides the classes and treatment services to those psychiatrically admitted to the [b)(2)-2] Patients sleep on the ward in the CSH at night, but are transported to the CSC for a day treatment program. At both [b)(2)-2] psychiatrists assigned to the CSC teams have admitting privileges and provide the needed BH specialty services at the local CSH.

Finding #7: There is one CSC reconditioning program in theater.

In addition to a restoration program, the CSC company element in Baghdad has a structured program for holding Soldiers with psychiatric mental disorders and good prognosis for RTD for up to 3 weeks. The program combines milieu therapy, OT, psychotherapy, and medication (as needed).

RECOMMENDATIONS

Recommendation #1: Use an empirically derived staffing model for BH personnel allocation and distribution.

Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater, providing a ratio of 1:851 BH personnel to Soldiers. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage. The ratio of BH personnel to Soldiers in OIF-II is 1:407, substantially different than last year.

Future staffing decisions for OIF and similar stability/support operations need to take into consideration the operational environment in theater, the OPTEMPO,

and other factors. Military planners need to tailor the BH force package based on the size of the force, the distribution of the force (number of FOBs), the amount/type of services desired in theater (see TAB A for a full discussion of a staffing model), and the availability of personnel and resources to provide this staffing level.

Based on the BH consultants to The Army Surgeon General, Human Resources Command, and MEDCOM Operations, there are significant concerns about being able to sustain current staffing levels of BH assets in theater with the existing AMEDD infrastructure. In addition, there are no data that demonstrate what the optimal number of BH professionals in theater should be. For many BH issues, leadership, training, unit cohesion, morale, and quality of life are probably as important as the number of BH personnel available.

The methodology in TAB A of this appendix provides a general model for determining staffing levels. It is intended to be a guide, not the definitive answer on what the optimal staffing level should be. Any model that is used should be needs based, empirical, and driven by operational requirements and Army doctrine.

Recommendation #2: Continue forward-deployed outreach to ensure Soldiers can access BH services.

Recommendation #3: Ensure all BH personnel can provide (with supervision and medical support) the full range of BH services.

It is important to maintain strong coordination amongst the various BH personnel in theater (whether from division, CSC, CSH, etc.) to assure that Soldiers have access to BH services when needed. Personnel who conduct outreach at the unit level or are the sole provider at a particular location should be able to provide the full range of services to include clinical evaluation and treatment, triage, referral, prevention, consultation, and education. Likewise, clinical staff at large FOBs (at CSHs, restoration units, etc.) should be able to provide outreach routinely.

Recommendation #4: Develop and implement a plan to assure that there will be adequate BH resources to sustain the BH mission over the next several years.

The current BH infrastructure was not designed for the OPTEMPO of the Global War on Terrorism. The increase in PERSTEMPO is leading to high levels of attrition of BH personnel and impacting other healthcare and professional training missions. Medical operation and military personnel planners should develop and coordinate a plan to allocate resources based on desired service levels and ensure that there are enough personnel to sustain current and future operations.

Table 1: Behavioral Health Personnel Ratios in OIF-I and OIF-II

	OIF-I (SEP 2003)			OIF-II (SEP 2004)		
REGION	BH	SOLDIERS	RATIO	BH	SOLDIERS	RATIO
(b)(2)-2						
IRAQ TOTAL	140	116000	830	215	83200	387
(b)(2)-2						
KUWAIT TOTAL	23	22000	943	17	11250	662
GRAND TOTAL	*163*	*138000*	*851*	*232*	*94450*	*407*

Note: Number of Soldiers is rounded for Operations Security (OPSEC).

Table 2: OIF-II Behavioral Health Personnel by Service

Specialty	TOTAL	Army	Navy	USAF
Psychiatrist	**18**	15	1	2
OT	**8**	8		
Psych Nurse	**14**	12	2	
Soc Work	**30**	27		3
Psychologist	**19**	17		2
Medic	**5**	5		
OT Tech	**8**	8		
MH Specialist	**130**	120	3	7
TOTAL	**232**	**212**	**6**	**14**

Table 3: OIF-II Behavioral Health Personnel by Unit and Unit Type

Unit	Unit Total	Ψiatry	OT	Ψ Nurse	Soc Wk	Ψology	OT Tech	MH Spec
(b)(2)-2								

(b)(2)-2

(b)(2)-2

(b)(2)-2

(b)(2)-2

Table 4: Behavioral Health Personnel Ratios By Forward Operating Base Size

		TOTAL				WITH BH PERSONNEL				W/O BH P
AOR	FOB Size	# of FOBS	# of Soldiers	# of BH	Ratio (1:X)	# of FOBS with BH	# of Soldiers	# of BH	Ratio (1:X)	# of FOBS w/o BH
IRAQ	(b)(2)-2									
	All Iraq	*64*	*83350*	*215*	*388*	*28*	*65650*	*215*	*305*	*36*
KUWAIT	(b)(2)-2									
	All Kuwait	*10*	*11150*	*17*	*656*	*2*	*6150*	*17*	*362*	*8*
THEATER	*All Theater*	*74*	*94500*	*232*	*407*	*30*	*71800*	*232*	*309*	*44*

Note: Number of Soldiers is rounded for OPSEC.

Table 5: Behavioral Health MOS by Forward Operating Base Size

AOR	FOB Size	# of FOBS	Total # of BH	# of Psychia-trists	# of Psychol-ogists	# of Soc Workers	# of OTs	# of Psych Nurses	# of MH EMs	# of OT EMs
IRAQ	(b)(2)-2									
	All Iraq	*64*	*215*	*15*	*19*	*26*	*8*	*13*	*126*	*8*
KUWAIT	(b)(2)-2									
	All Kuwait	*10*	*17*	*3*	*0*	*4*	*0*	*2*	*8*	*0*
THEATER	*All Theater*	*74*	*232*	*18*	*19*	*30*	*8*	*15*	*134*	*8*

Table 6: Disposition of Inpatient MH Assets as of 1 October 2004

AOR	FOB	UNIT	Total Staff	Psychiatrists	Psych Nurses	Psychologists	Social Workers	MH EMs
IRAQ	(b)(2)-2							
KUWAIT	(b)(2)-2							

Table 7: Disposition of Restoration Assets as of 1 October 2004

AOR	FOB	UNIT
IRAQ	(b)(2)-2	
KUWAIT	(b)(2)-2	

TAB A: Behavioral Healthcare Staffing Model

Last year's MHAT Report (Office of The U.S. Army Surgeon General, 2003) discussed several methods for evaluating BH personnel strength in OIF-I (Kuwait and Iraq). Those methods included Unit Basis of Allocation (in accordance with FM 8-55) and BH personnel to Soldier ratios. Last year's MHAT concluded that a ratio of one BH personnel for every 851 Soldiers was sufficient to provide needed coverage. This year, the ratio has increased to one to 407 Soldiers because of an increase in BH personnel in theater and an overall decrease in the Soldier population.

This analysis includes only Army Soldier populations, Army BH personnel, and those Navy and Air Force BH personnel who are primarily serving Army Soldiers.

Staffing Models

Faulkner and Goldman (1997) posited five approaches to estimating the number of BH personnel needed to staff a civilian MH system. Most of these look at the existing number of BH personnel and try to determine if they can meet the needs of the service population. However, as Elisha, Levinson, and Grinshpoon (2004) point out, approaches that are based on the existing number of BH personnel "tend to perpetuate distortions in staffing patterns, give little weight to clients' needs, and lack a conceptual rational" (p. 325).

One of Faulkner and Goldman's (1997) approaches begins with an estimate of the population needs and demands. Calculations are based on three variables:

1. The number of individuals who need services as determined by a population-based psychiatric morbidity survey.

2. The percent of individuals likely to demand BH services as determined by records or estimates of service utilization.

3. The amount of time/effort BH providers have to put forth to provide the services needed as determined by workload efficiency data.

In addition to these three variables, Faulkner (2003) and Elisha, et al. (2004) parse the need into those tasks that a psychiatrist must perform, and those any other MH professional can perform. For this analysis, we will parse the need into officers and enlisted, assuming that a further analysis will need to take place amongst the officer corps to determine the appropriate mix of areas of concentration (AOCs) in theater.

Staffing Model Assumptions

This analysis makes a number of assumptions that may not remain valid under differing circumstances in the theater of operation. Any use of this model requires careful analysis of each assumption, and the overall product must be weighed against

METT-TC (Mission, Enemy, Terrain and weather, Troops and support available, Time available, Civil considerations).

For this report, the following assumptions have been made:

1. *Approximately 11% of the population will receive BH care during the course of the deployment.* This is based on multiple sources of data. As noted above, we examined three variables: those who want help, those who need help, and those who usually use help.

a. Want help. On the OIF-II survey, 11% of all Soldiers reported a desire to get help for a stress, emotional, alcohol, or family problem (see Annex A).

b. Need help. Regarding estimated treatment need, 13% of OIF-II Soldiers who were surveyed screened positive for depression, anxiety, or PTSD.

c. Normally use help. Data from the Walter Reed Army Institute of Research (WRAIR) Land Combat Study indicated that 7-11% of Soldiers surveyed 3-4 months after returning from OIF-I used BH services in the past year (this includes the deployed period). In the current OIF-II survey, 9% of Soldiers reported that they had seen a BH provider at least once during the deployment. (Soldiers were surveyed on average 7 months into the deployment, but this cannot be directly extrapolated to a year deployment since Soldiers do not seek care uniformly throughout the year.) These rates are very similar to Army-wide ambulatory BH service utilization. Overall, eight percent of the Soldiers reported that they had seen a MH professional within the last year according to the most recent DoD Survey of Health Related Behaviors Among Military Personnel (Bray et al., 2003).

2. *Soldiers who receive BH care will have, on average, three clinical visits.* Available DoD healthcare utilization data indicate that the median number of visits is 2; however, high utilizers may drive the mean higher than this. Therefore, we chose a conservative estimate of three visits per Soldier receiving care.

3. *On average, BH providers will be able to provide individual outpatient clinical support to up to six Soldier visits a day, 6 days a week (or 36 visits/week/provider).* These numbers include both initial appointment and follow-up visits; they also include both diagnosed patients and Soldiers who are experiencing combat and operational stress symptoms and require intervention. The MHAT members determined the ratio (36/week/provider) based on their collective clinical experience and observations in theater.

4. *All FOBs with Soldier populations over 1,000 will need a BH officer.* Although there may be FOBs with over 1,000 Soldiers who can be adequately covered by neighboring FOBs, or staffed by BH NCOs instead of officers, for this planning model, we assumed the need for a BH officer at each FOB over 1,000. For each FOB over 1,000 Soldiers, there would be at least 1 officer and 1 MH specialist (91X) providing clinical services

and outreach (see #5 below). Larger FOBs would require additional BH professionals to provide clinical and/or outreach to the additional population. (b)(2)-2

(b)(2)-2

(b)(2)-2

5. *Behavioral health outreach, consultation, prevention, and education services provided at the unit-level will require approximately 8 hours (1 duty-day) per battalion-size unit per week.* This time allows for travel time and coordination. It is expected that some battalions will require substantially more time than this (e.g. travel time/waiting for convoys, etc), while others that are collocated on the same FOB with the BH professionals will require less time for these services. For planning purposes, BH enlisted Soldiers provide these services under the supervision of the officer on the same FOB, although they may switch responsibilities as needed.

6. *The average restoration unit will hold about 4 Soldiers at a time; the reconditioning units will hold about 8.* Based on observations from OIF-I and OIF-II, the MHAT noted that the restoration units in theater rarely held more than 4 Soldiers at a time. Calculations on the number of BH personnel needed for these missions are based on Tables 3 and 4, below.

7. *Combat Support Hospitals (CSHs) will deploy with their doctrinal 4 BH personnel (2 officers and 2 enlisted).* The BH personnel are included in the calculations as providing basic clinical support on large FOBs.

8. *Behavioral health officers have differing capabilities, but can provide a full range of care, given proper supervision and consultation.* Although communication types and sophistication levels vary from FOB to FOB, in general, communications have improved significantly since last year (OIF-I). Given the improvement in the telephone and e-mail systems, and the availability of psychotropic medication support from a PC physician/PA, most BH officers should be able to provide the full range of BH services 24/7. In addition, enlisted BH personnel can provide BH services given proper consultation, staffing, and supervision. For purposes of this analysis, all officer specialties are assumed to be interchangeable. Further analysis is required to differentiate which specific specialties are needed for a given operation.

9. *Some BH personnel are required to fill command, control, and staff functions in addition to those needed for clinical and outreach services.* Because BH officers and NCOs hold staff positions within medical brigades, and command and leadership positions within CSC units and other units, additional time (resources) must be factored into the model. For this model, we have chosen a ratio of one leader/staff officer for every fifteen BH personnel (1:15). This ratio would provide the equivalent of three fulltime leadership personnel in a CSC unit.

Further Discussion of Assumptions Underlying the Model

The nature of combat and the combat environment requires staffing redundancy and flexibility not needed in CONUS, peacetime, or civilian staffing models. These intangible factors include efforts to secure basic life support and supplies, efforts to arrange for and conduct convoy operations to remote locations, personnel surges on the battlefield (due to unit rotations or local battle concentrations), mass casualty events, and possible loss of BH personnel due to casualties, emergency leave, etc.

As critical events and battle concentrations occur in differing areas, additional BH personnel may be temporarily needed to augment certain areas/units. Whether sent as individuals or "quick reaction teams," the flexibility to surge BH personnel from one battlefield area to another requires sufficient resources be in theater to continue universal minimal services while staffing such missions.

To address these considerations, this staffing model builds in flexibility to allow the BH care system to respond to these types of factors.

1. The total number of BH care visits among Soldiers who access care was assumed to be 3, whereas the average, based on all available data, is 2. Thus, estimated actual clinic utilization is likely to be lower than predicted by the model.

2. Outreach at the battalion level is assumed to take 1 entire day for each battalion, visited once every week. Some battalions may need more time than this, particularly given the difficulties with travel. However, some battalions may need to be visited less frequently, based on the outcome of an individualized unit needs assessment. It may not take an entire day to conduct outreach to a battalion collocated with the BH professional.

3. All bases with more than 1,000 Soldiers were assumed to have at least 1 BH officer and 1 BH enlisted professional on-site, whereas Soldiers on the smaller bases (b)(2)-2 are assumed to receive services either through BH outreach at the battalion level (staffed for the whole theater) or through Soldiers traveling to the location of the BH professionals (also staffed for the whole theater).

4. Behavioral health professionals could work more than 6 days a week if necessary. Also, they may provide one-on-one BH care to more than six Soldiers per day.

5. Personnel at the CSHs are not considered in the calculations. This provides, on average, 2 additional BH personnel on each of the FOBs where a CSH slice is located. These individuals can provide some of the FOB outpatient clinical work or they can be used for outreach to units on the local FOB, contingent on the workload at the CSH.

6. The current staffing is based on calculations for the entire theater with the same level of staffing for Kuwait as in Iraq. Based on the data from the Soldier Health and Well-being Survey, the MH care needs are greater in Iraq than in Kuwait. While theoretically resources from Kuwait could be shifted to support Iraq bases, in practice this is problematic given the different commands.

In addition, it is assumed that there will be flexible utilization of BH personnel. For planning purposes for this model, BH officers were identified as the primary professionals (as credentialed professionals) responsible for clinical care and enlisted BH personnel as the primary personnel for conducting outreach services. However, in practice this is highly flexible, with officers frequently providing outreach and education and enlisted personnel providing clinical services. The staffing model is designed to allow for this flexibility. The model only generates an estimate of the total number of personnel that may be needed in theater. Operational and medical leaders, guided by the tactical/operational situation and Army doctrine, determine how these personnel are allocated and used.

Behavioral health personnel are currently assigned to, and deploy with, Division/Brigade Mental Health Sections, CSC units, CSHs, Area Support Medical Battalions (ASMBs), Area Support Medical Companies (ASMCs), etc. Nothing in this staffing model is meant to detract from the current organization tables or methods of personnel deployment; however, medical planners may use this staffing model to determine how many units or unit slices to deploy. This model provides an estimate of the number of BH personnel needed to provide care, outreach, etc.; it does not assume or restrict where that support should come from (Division Mental Health Sections, CSC units, or individual augmentees).

Staffing Model Calculations

Using these assumptions, we calculated three increasing "components" of care, each built upon the previous one. These components can be stacked up as need, command support, and resources allow.

The first of these is a clinical services component. It provides for clinic-based outpatient care on all FOBs with a Soldier population larger than 1,000. It also provides some inpatient care capability by using CSH behavioral health assets. The calculations for this component are based on population estimates of psychiatric morbidity (need), desire for care, and past patterns of utilization.

The second service component provides unit outreach. These additional BH personnel extend the clinical mission by adding preventive counseling, command consultation, unit needs assessment, Soldier classes, coordination with UMTs and PC providers, etc. The calculations for this component are based on the number of battalion-size units needing outreach, and the frequency of that need. With this model, officer and enlisted staff members located on each FOB could switch off duties as needed to provide clinical and outreach services.

The third service component adds additional personnel to staff regional restoration units that provide a location and up to a 3-day program as an intermediate care facility. This component also provides for a reconditioning unit in theater to provide longer-term restoration and reconditioning services (up to 21 days) to Soldiers from all over theater. These calculations are based on a new restoration/reconditioning unit staffing model found at the end of this TAB.

Table 1 presents an estimate of the BH staffing levels for each component of care based on OIF-II data as of 1 October 2004. In addition to the number of officers and enlisted for each component, the table shows the "running totals" and "running ratios" (ratio of 1 BH personnel to the number of Soldiers). The data used for this table will likely change for OIF-III and thus require a new staffing calculation.

Table 1: Operation Iraqi Freedom Behavioral Health Functional Components Staffing Model (Based on OIF-II Soldier Population of 95000, 1 October 2004)

BASIC COMPONENTS	Off	Enl	Ldrs	TOTAL	Running Total	Running Ratio (1:X)
Clinical Services (FOBs >1000)	32	32	4	**68**	**68**	**1386**
Unit Outreach	0	32	2	**34**	**102**	**929**
3 Rest/1 Recond Units (Avg 4-8 pts)	10	10	1	**21**	**123**	**770**
TOTAL	**42**	**74**	**7**	**123**		

Using the assumptions noted in the sections above, the staffing projection for the OIF (Kuwait and Iraq) population (as of 1 October 2004) is 123 BH personnel (42 officers, 74 enlisted, and 7 leaders—a mix of officers and senior NCOs). This would provide one BH personnel for every 770 Soldiers in theater—a ratio in between the current level of staffing, and that of OIF-I.

The model allows for differing assumptions. For example, it may not be reasonable to lump Iraq and Kuwait together since they have different needs and different command structures. If one wishes to only look at Iraq (assume Iraq data is that of 1 October 2004—see Annex B, Table 4), wants to ensure that there are 2 officer providers on each FOB larger than 1,000 (plus additional enlisted BH staff), and thinks that outreach to each battalion-sized unit will take 2 days on average instead of 1 day, then new staffing levels can be calculated. These new parameters would result in 183 BH personnel (58 officers, 114 enlisted, and 11 leaders—a mix of officers and senior NCOs). This would provide one BH personnel for every 456 Soldiers in Iraq (see Table 2).

Table 2: Operation Iraqi Freedom Behavioral Health Functional Components Staffing Model (Based on Iraq-Only Soldier Population of 84,000, 1 October 2004, Two Providers on FOBs >1000, and 2 Outreach Days per Week per Battalion)

BASIC COMPONENTS	Off	Enl	Ldrs	TOTAL	Running Total	Running Ratio (1:X)
Clinical Services (FOBs >1000)	48	48	6	**102**	**102**	**815**
Unit Outreach	0	56	4	**60**	**162**	**515**
3 Rest / 1 Recond Units (Avg 4-8 pts)	10	10	1	**21**	**183**	**456**
TOTAL	**58**	**114**	**11**	**183**		

The model can thus be used for a range of situations, depending on the facts one has and the assumptions one makes at the time of the estimate. If further redundancy is desired, the planner may choose to increment the numbers by an additional percentage (add a "fudge factor").

Additional Information on Staffing Model Calculations

Clinical Services Component

1. The estimated number of Soldiers needing help was determined by multiplying the Soldier population by the average of the percent of Soldiers wanting help (11%), needing help (13%), and usually using help (10%). The result was 10,500.

[SoldiersServe] = [Soldier population] * ([%WantHelp] + [%NeedHelp] + [UseHelp]) / 3

2. The estimated total number of visits for a deployment year is 31,500 (10,500 times the number of visits per Soldier, 3).

[TotalVisits] = [SoldiersServe] * 3

3. 31,500 visits require 17 officer providers seeing six Soldiers per day, 6 days a week.

[Providers] = ([TotalVisits] / (365*6/7)) / 6

4. However, 17 providers will not provide adequate coverage for all 23 FOBs with populations>1,000 Soldiers. Therefore, one must have at least 23 (one for each FOB) plus an additional 9 for FOBs with large populations (over 3,500) in order to cover the required clinical workload. This results in a total of 32 clinical providers. This was increased for Table 2, above, to assure at least 2 officers (and two enlisted) could be placed on each FOB over 1,000.

[ClinProviders] = The Greater of ([Providers] OR ([NumFOBs>1000] + [NumFOBs > 3500])

5. To support and extend the clinical mission, 32 enlisted soldiers (one for each officer provider) will deploy as well. This results in a total of 64 BH personnel to provide clinical

coverage at the 23 FOBs throughout theater with Soldier populations greater than 1,000 (see Table 1, above).

[Enlisted] = [ClinProviders]

6. In addition to clinical providers, for every 15 BH personnel, one additional person (or "full time equivalent") is added to the model to allow for command, control, and staff functions. This adds 4 additional personnel (could be any combination of additional officers or senior enlisted personnel), for a total of 68 BH personnel.

[Total] = [ClinProviders] + [Enlisted] + (([ClinProviders] + [Enlisted]) / 15)

Unit Outreach Component

7. Outreach staffing numbers are based upon a BH officer or enlisted member spending 1 day each week with each battalion-sized element in theater. This time can be used doing need assessments, command consultation, liaison with chaplains and PC providers, providing on-the-spot interventions, classes, setting up and training the battalions' Soldiers in a train-the-trainer mode, etc. We did not have the exact number of battalions in theater, but estimated it by taking the total Soldier population and dividing it by 500 (approximately 500 Soldiers in a battalion). This resulted in the need for 189 person-days per week. This was divided by 6 (the number of work days per week), resulting in the need for 32 additional personnel. For our analysis, we assumed that this work could be done in large part by 91Xs under the supervision of the BH officer at the FOB or on a nearby FOB. This resulted in the need for 32 additional enlisted BH personnel. For Table 2 this was changed to assume that it would take 2 days for each battalion.

[OutreachPeople] = ([NumBNs] * [NumDaysOutreachPerBN]) / 6

8. The additional personnel also require one leader for every 15 personnel, so 2 additional leaders are needed.

[Total] = [OutreachPeople] + ([OutreachPeople] / 15)

Regional Restoration and Theater Reconditioning Component

9. The number of personnel needed to staff a regional restoration program or a theater-wide reconditioning program was drawn from the Staffing Model below. We assumed that restoration programs in OIF and comparable scenarios would not hold more than 4 Soldiers on average, and that a reconditioning program would not hold more than 8 Soldiers on average. Restoration programs required 2 officers and 2 enlisted staff to serve a 1:4 ratio. Since there are three regional restoration programs, this resulted in 6 additional officers and 6 additional enlisted personnel.

10. From the staffing guidelines below, a reconditioning program needs 4 officers and 4 enlisted personnel to support a 1:8 ratio.

11. Adding these together results in the need for 10 more officers and 10 more enlisted personnel to support 3 regional restoration programs and one theater-reconditioning program.

12. Finally, one must add one additional leader (or "full time equivalent") for the 20 BH personnel performing restoration/reconditioning services; this results in a total of 21 BH personnel to conduct restoration and reconditioning in theater.

Combat Stress Control Restoration and Reconstitution Staff Models

The MHAT noted that some CSC restoration programs had more personnel than they needed to care for the Soldiers being referred to them. The theater BH consultant stated that some of these personnel are used as rapid reaction teams for surges and psychological mass casualties (MASCALs). Current base tables of organization and equipment (BTOEs) implies incorrectly that a restoration or fitness section works as (and only as) a single entity. However, current teaching and the rewritten draft COSC field manual clearly state that all CSC teams, and especially fitness teams, must routinely split into smaller, dispersed elements, as needed to fulfill specific missions. The Army Transformation CSC unit will be composed of 3-person mobile teams that can provide outreach services or can be assembled to provide restoration or reconditioning. This will provide planners and leaders with more flexibility and freedom to adapt to mission requirements. As noted above, certain specialties (like OT) are needed at restoration units. However, any persons and/or time not fully used in providing restoration/reconditioning care should be shifted to provide preventive outreach to units on the local FOB.

Behavioral health inpatient wards have developed staffing-to-patient models, but restoration units and prevention teams have not yet identified such models. In actual practice, the independent capability level of any particular BH team or unit is based on two critical aspects: (1) The licensure/regulatory limitations imposed and the experience of the team members, and (2) The capability/capacity of the BH team/unit to hold and treat Soldiers/patients. Behavioral health teams with the appropriate capability ratings should be matched (and not over-matched) with mission needs.

Table 3 describes the various capability levels that a BH provider or team may assume based on the specialized capabilities of its member(s). Table 4 describes the levels each BH provider or unit may assume based on ability to provide holding capacity.

Using Table 4, each proposed restoration program should be able to gauge the appropriate number and mix of personnel needed to care for a given number of Soldiers. For example, if a unit is providing care for 1 to 4 Soldiers, they will need two full-time 91Xs, an OT or OT technician, and a social work or clinical psychology officer. If the number of Soldiers in restoration is increased to eight, the unit would need 3 fulltime 91Xs, 2 OTs or OT technicians, and one social work or clinical psychology officer. These tables and ratios are meant to be guidelines; leaders must take into

consideration operational and environmental factors when staffing units on the battlefield.

Table 3: Combat and Operational Stress Control Specialty Capability Levels

Specialty Care	Enlisted 91X	BH Officer	BH Officer w/Cmd-Directed Eval Capability IAW DoD 6490.1	BH Officer w/ Prescribing Privileges
Program Content	Outreach; Consultation; Basic Assessment; Soldier Coaching	+ Full Assessment; Outpt management; Outpt treatment	+ Self-contained evaluations of command-directed evaluations in non-emergent environs	+ On-site medication management
Specialty Support	Lone 91Xs should be NCOs. Junior enlisted may be used if senior (E7) 91X or BH officer telephone/email support is available 24/7.	OT officers may be used if a licensed BH clinician's telephone/e-mail support is available 24/7.	Non-PhD BH officers can evaluate Cmd-directed cases in emergent conditions. They can evaluate routine Cmd-directed cases if PhD-level BH clinician telephone/e-mail support is available 24/7 and the case is reviewed and countersigned when a PhD provider is available.	Non-prescribing BH officers should use available PA/ physician support for basic medical management. Poly-pharm and/or potentially complicated medical management cases must have available psychiatrist telephone/e-mail support 24/7.
Documentation	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records • Cmd-directed cases — cmd-directed forms	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records • Cmd-directed cases -cmd-directed forms

Table 4: Holding Capability Levels

CAP	2a Unit Holding	2b Medical Holding	2c Restoration	2d Reconditioning	2e Inpatient Ward
Unit	Soldier's or nearby supporting unit	Non-BH Medical Unit	BH/CSC Unit	BH/CSC Unit	BH Inpatient Ward
Program Content	Rest, reassure, replenish, and restore confidence (4Rs)	• 4Rs; Monitoring; Stabilization	2b + OT Assessment	2c + OT Program	• Secure environment • Stabilization • Medication Management
Program Length	As needed	1-3 days	1-3 days	4+ Days	As needed
Specialty Care	91X + supervision	91X + supervision	CAP 1b + OT/91WN3	CAP 1d + OT + PN	CAP 1d + PN
Personnel Requirements	Unit members provide watch as needed.	• 91X – 1:4 • 91W – per med unit's staffing SOP • Medical officer supervision – per med unit's staffing SOP	• 91X – 1 + 1:4 • OT/91WN3 – 1:6 • CAP 1b Off – 1:12	• 91X – 1 + 1:4 • 91WN3 – 1:6 • OT – 1:12 • PN – 1:12 • CAP 1b Off – 1:12 • CAP 1d Off – 1:30	Based on BH inpatient ward staffing model used by the particular hospital, augmented if necessary by CSC unit
Milieu	w/unit and peers	w/other med patients	Occ Milieu	Psych/Occ Milieu	Psychiatric Milieu
Identification	Soldier at Rest	Soldier in Holding	Soldier in Holding	Soldier in Recovery	Patient
Documentation	• COSC-WARS • Brief BH note in outpt record	• COSC-WARS • Brief BH note in outpt record	• COSC-WARS • Brief BH summary in outpt record	• COSC-WARS • Full notes in BH chart • Summary BH note in outpt record	• Full inpt medical chart • Admission and disposition notes in outpt chart

Note: *91X = Enlisted Mental Health Specialist; 91WN3= Enlisted Occupational Therapy Technicians; OT = Occupational Therapist; PN = Psychiatric Nurse; SOP = Standing Operating Procedures*

APPENDIX 6

BEHAVIORAL HEALTH RETURN-TO-DUTY AND WORKLOAD DATA

INTRODUCTION

As part of the MHAT mission, electronic workload, evacuation, and RTD data were collected from various BH units. These units included: CSC detachments; a CSC company; division, brigade and area support medical company MH sections; CSH psychiatric sections; and USAF teams that supported primarily U.S. Army troop populations. Many units did not respond to the data call, and in other cases, the data received were difficult to standardize for comparison. However, the usable data provided by some units allowed us to arrive at some findings and recommendations.

FINDINGS

Finding #1: Behavioral health assets had high RTD rates.

All forward-deployed BH assets in OIF-II Iraq had high RTD rates (See Table 1). One separate brigade BH team with two each organic officers and 91Xs returned 100% of the Soldiers/patients that its DMHS evaluated. The two DMHS's and another separate brigade's rates were above 96%. The one CSC Company, deployed for a time at 15 separate FOBs throughout Iraq, returned 95% of the Soldiers provided 1-on-1 preclinical or clinical care. The Air Force's (b)(2)-2 operational stress teams in Kuwait had RTD rates (97%) comparable to the Army's forward-deployed BH units.

Table 1: OIF-I and OIF-II Return to Duty By Type of BH Team/Unit

Type of Unit	Dates	% RTD	
		OIF-II	OIF-I
Division MH Sections	Apr-Aug 04	97%	97%
Separate Brigade MH Sections*	Apr–Aug 04	99%	---
Combat Stress Control Unit	Aug–Sep 04	95%	96%
USAF Combat Stress Teams	Jun-Aug 04	97%	96%
CSH (with CSC R/R)**	Apr–Aug 04	80%	69%
CSH (Psych Inpatients only)*	Apr–Aug 04	4%	---
Regional Medical Center (Germany)	Mar-Sep 04	3% ***	4%

** No data from a comparable unit in MHAT-I Report*
*** R/R = Restoration/Reconditioning Program*
**** LRMC OIF-II RTD was 0% for inpatients, 3.7% for outpatients.*

Soldiers returned to duty from divisions, separate brigades, and CSC units included both non-inpatient "psychiatric" and "combat/operational stress reactions." Non-inpatient RTD rates in the high nineties suggest that forward-deployed BH personnel are retuning almost all Soldiers they help/treat for both stress and mental problems immediately to their units.

The CSC reconditioning program treats selected Soldiers with diagnosed mental disorders who have not responded to outpatient treatment or a 3-day restoration program, but who were still judged to have worthwhile RTD potential. Since many units (particularly reserve units) do not receive replacements during the 1-year deployment, a program that can treat Soldiers and return them to duty is a force multiplier. The program's RTD rate from reconditioning could not be reliably calculated from the records available to the MHAT-II. Continual analysis is required to judge whether the BH personnel involved in treating the reconditioning cases would have greater impact on overall combat effectiveness and soldier well-being if they were employed further forward for outreach and outpatient interventions.

The OIF-I combat support hospital had its own small psychiatric ward and additional staff. The OIF-II combat support hospital could only admit psychiatric casualties on an intermediate medical care ward. However, the OIF-II combat support hospital worked closely with the CSC unit's restoration/reconditioning program. Soldiers admitted to one unit were often treated and/or quartered by the other. In general, Soldiers were seen at the CSHs in either an outpatient or inpatient mode. Soldiers seen as outpatients (including those who were temporary residents in the neighboring CSC unit restoration program) had a much higher RTD rate (80%) than did those Soldiers who were admitted as inpatients to the intermediate care ward (4.3%). This lower 4.3% RTD rate reflects the severity and poor prognosis of their conditions in the psychiatrist's clinical judgment. Less severe cases with better prognosis were admitted to the nearby CSC facility, which also has psychiatry, psychiatric nursing, and OT capabilities focused on RTD.

Finding #2: A tracking system for CSC preventive and preclinical individual contact activities has not yet been universally implemented in the OIF Theater.

The attempt to gather and compare data from various units in OIF-II clearly demonstrated a need to both standardize and enforce mandatory reporting of common data. Although the CSC/BH units under the Medical Brigade and the two divisions in OIF-II use the COSC-WARS summary report, some units use it differently. Some users made variations in the line formats or misinterpreted what data to enter into certain fields, thus making comprehensive compilation and analysis impossible.

The CHPPM's automated version of COSC-WARS is one option that AMEDD Combat Developments is using as the test-bed for developing contract specifications for the COSC functional area in the Theater Medical Information Program (TMIP). Automated COSC-WARS is developing the capability to capture the data at the single-event level, generate summary reports, enable temporary archiving in theater for local use, and permanently archive the initial data and reports in CHPPM's secure, searchable surveillance database, which can respond to inquiries from Theater. The program operates on laptops and handheld and desktop computers, with electronic synchronization and transmission. Coordination has begun to add COSC-WARS capabilities to the medical communications for combat casualty care (MC4) system.

Further assessment and coordination is needed to ensure that the existing system (COSC-WARS) meets BH and theater requirements.

Finding #3: Combat Stress Control (CSC) units contribute to outreach efforts.

Table 2 demonstrates the types and quantity of outreach and early intervention that one CSC Company accomplished in a 7-month timeframe. This workload represents the equivalent of 52 debriefings, 198 classes, 1,160 unit visits, and 274 command consultations per month. Organic BH assets also do outreach, but through augmentation, CSC behavioral health personnel can greatly assist organic outreach (and other BH service) efforts. TAB A contains definitions for workload categories noted in Table 2.

Table 2: Preventive Outreach Activities of a CSC Unit in OIF-II, March–September 2004 (Summing Weekly COSC-SRs)*

Activities	Total Number
Critical Event Debriefings	**364**
# Critical Events	178
# Participants	2587
Other Debriefings	**91**
# Participants	1746
Health Protection Classes	**1097**
# Participants	8405
Mission-focused Classes	**290**
# Participants	5295
Unit Surveys	**29**
# Questionnaires Received	1122
Command Consults (Not case related)	**1921**

**The company had approximately 80 personnel to conduct preventive activities, about 68 of them clinically trained. From March to June, the summary reports (SRs) came weekly to the CSC Company HQ from* (b)(2)-2 (b)(2)-2 (b)(2)-2

Based on these statistics, the CSC Company provided an average of two CED sessions for each critical event they responded to, with an average 7 Soldiers in each debriefing. This is consistent with training guidelines. There were fewer "Other debriefings;" these averaged 19 participants per session.

Approximately 8 Soldiers attended the health protection classes on average. Examples of these classes included individual Soldiers attending anger management or tobacco cessation classes. Mission focused classes, on the other hand, averaged 18 participants per session; most likely these were coordinated with specific units for members of that unit.

Finding #4: Behavioral health providers rated "relational factors" as the predominant contributing factor to Soldiers' chief complaint.

Table 3, below, reports what BH personnel in a DMHS recorded as the primary stressors or contributing factors in the COSR and psychiatric cases they interviewed and aided/treated. Their evaluations integrated the chief complaints of the individual Soldiers with their own knowledge and experience in the etiology of emotional distress and mental disorders. They perceived relational issues as the major factor in the majority of cases (58%). Of these relational issues, problems in relationships on the home front were considered the most common, followed by problems with peers in the unit, then leadership conflicts. Individual causes were perceived as the next highest contributor to the symptoms (26%); these causes included preexisting disorders, "conditional" ("I'll get better only if you send me home"), and character traits. Operational exposures, including traumatic events, were perceived as primary causes in 11%. See TAB B for definitions of the below contributing factors.

Table 3: Contributing Factors to Soldiers' Stress Reactions (From a DMHS' Weekly COSC-SR; Jan - Aug 2004)

Contributing Factors	Number	Percent
Operational Exposures	**252**	**11%**
Combat Exposure	125	5%
Noncombat Critical Event	127	5%
Relational Factors	**1345**	**58%**
Peer/Unit	460	20%
Leadership	312	13%
Home Front	575	25%
Environmental Exposures	**129**	**6%**
Physical/Environmental	45	2%
Mission Requirements	84	4%
Individual Causes	**607**	**26%**
Characterological Factors	244	10%
Conditional	72	3%
Preexisting Condition	301	13%

Number of Soldier Visits = 1,575.
Behavioral health personnel could record up to 3 factors/case.

RECOMMENDATIONS

Recommendation #1: All BH/CSC personnel use a single standard format for documenting preventive encounters and interventions.

Theater BH assets should use an identical format for recording their COSC-type activities and cases. The teams may use different portions of the format, and report only what higher headquarters specifies in the SOP. The documentation must merge within the BH/CSC teams to produce the unit's weekly summary, and by higher headquarters to combine the summary reports across units and over time for ongoing trend analysis, resource redistribution, and follow-up assessment.

The CHPPM's automated version of COSC-WARS is one option. The AMEDD Combat Developments is using COSC-WARS as the test bed for developing contract specifications for the COSC functional area in the TMIP. Automated COSC-WARS has the baseline capability to capture the data at the single-event level, generate summary reports, enable temporary archiving in theater for local use, and permanently archive the initial data and reports in CHPPM's secure, searchable surveillance database, which can respond to inquiries from theater. The program operates on laptops and handheld and desktop computers, with electronic synchronization and transmission.

Recommendation #2: Cooperation and synchronization of effort between organic MH sections and augmenting CSC teams should be fostered through task organization and clear command and control relationships.

The advent of the CSC units in 1993 added BH personnel to the deployed force, but experience has found that organic (division and brigade) and augmenting CSC personnel, teams, and units often have difficulty integrating within a single area of operations. Because CSC units (and their BH personnel) are corps-level assets, the corps medical brigade usually controls them. Further, the corps medical brigade commander may or may not be the Corps Surgeon, creating distinct chains of command for divisional BH personnel and CSC personnel. This split can result in different reporting formats, differential service standards, and most apparently, in overlaps and gaps in BH services in theater.

Logistics support of CSC units is another noted problem that has been raised through BH interviews and focus groups in both OIF-I and OIF-II. Because CSC units are a corps asset and often (as small teams) lack inherent supply, communication, and other necessary survival capabilities, coordination must be done when placed in a forward location to ensure adequate logistical support.

BACKGROUND

Study Sample

The units for which adequate workload and RTD data were obtained in time for this report are listed in Table 5. Some units provided data that were incomplete, inconsistent, or difficult to interpret. These units are also listed in Table 5.

Table 5: Units Contributing Data to the Data Call Appendix

Unit Data Used in Analyses	Unit Data Not Included in Analyses*
(b)(2)-2	

** Data not used because data was inconsistent, incomplete, or difficult to interpret within the time available*

Procedures

All major BH units and sections were queried via telephone and e-mail and/or in person between 9 September and 9 October 2004. Although some small, forward-located teams were not canvassed, their parent organizations were. A data matrix was e-mailed to the major units in September 2004 and again to non-responders a week or so later. Additionally, COSC-WARS summary reports compiled over time were received from (b)(2)-2 (b)(2)-2 Kuwait.

The electronic data call form is at TAB C. The standard data fields (numbered lines) of the manually recorded COSC-WARS Summary Report that the (b)(2)-2 Med Bde used is at TAB D. The MHAT archived the electronic data from the forms and of the e-messages related to the data used in this appendix in the Department of Military Psychiatry, Walter Reed Army Institute of Research (WRAIR), Silver Spring, MD.

TAB A: Definition of COSC-WARS Preventive Outreach and Intervention Terms

# of Critical Event Debriefing (CED)* Sessions
Number of debriefing sessions for Soldiers, leaders, others who were part of a critical incident

A Critical Event Debriefing (CED) is a form of psychological debriefing conducted by BH/COSC personnel at the request of units following a critical event (CE) for the purpose of clarifying the event, facilitating the team members' support for each other, and regaining unit cohesion and readiness for further action.

Total # of Attending CEDs
The total number of participants in all of the CEDs performed during the reporting period

# of Critical Events**
This is the number of all critical (combat and noncombat) events that has occurred within the reporting unit's area of responsibility during the time covered by the report.

A CE is an event that involves death, injury, or imminent risk thereof, and has high potential to produce emotions/cognitions of intense fear, horror, helplessness/hopelessness, guilt, etc., in some survivors and rescuers.

# of Other Debriefing Sessions
The number of debriefing sessions for Soldiers for reasons other than the aftermath of a critical event (for example, end of tour debriefings)

# of Force Health Protection (FHP) Classes
The number of classes given on FHP topics that are not related to a current deployment or deployment-phase. For example, FHP classes would include smoking cessation, anger management, stress management, suicide prevention, etc. Reunion classes are FHP classes if given generically, and not as part of a current deployment.

Total # of Attending FHP Classes
Total number of participants attending all FHP classes lead by the reporting unit during the reporting timeframe

# of Mission-Focused Classes
Mission-focused classes include those classes, courses, and briefings related to a current or pending deployment/mission. Pre-deployment briefings and re-deployment briefings (to Soldiers and/or family members, etc.) are mission-focused classes. Other examples include classes on: Continuous Operations; Psychological Aspects of Nuclear, Biological, and Chemical (NBC) Operations; Peacekeeping Operations, etc.

 # Consultations to Command or Other Med Pros
The number of nonclinical (i.e., not about an individual) command consultations or consultations to other medical professionals

TAB B: Definitions of Contributing Factors to Soldiers' Stress Reactions

# of Combat Exposure
The number of COSC contacts where the primary problem was attributed to direct combat exposure (lethal weapons used with deadly intent in the immediate vicinity, direct exposure to casualties, front-line action, etc.)

 # NonCombat Severe Event
The number of COSC contacts where the primary problem was attributed to a critical incident other than direct combat (suicide in unit, fatal accident, exposure to mass suffering or dead bodies, great danger, etc.)

 # Peer/Unit
The number of COSC contacts where the primary problem was attributed to a conflict with the unit or with a peer in the unit

 # Leadership
The number of COSC contacts where the primary problem was attributed to a conflict with or between leaders in the unit or to perceived poor leadership within the unit or at higher echelons of command

 # Home Front
The number of COSC contacts where the primary problem was attributed to an issue at home, conflict with family member, etc.

 # Environmental Factors*
The number of COSC contacts where the primary problem was attributed to environmental causes (living conditions, specific mission requirements, high operations tempo (OPTEMPO), sleep loss, continuous operations, mission-oriented protective posture (MOPP), resupply delay, etc.)

#Other Individual Factors*
The number of COSC contacts where the primary problem was attributed to individual causes (personality, malingering, expectation of secondary gain, etc.)

* The COSC-WARS Summary Report format (See TAB D) provided data entry fields for dividing Environmental Factors into two subcategories and Other Individual Factors into three subcategories.

TAB C: Electronic Data Matrix

Please complete these steps.

Step 1: Save this Microsoft Excel document to your hard drive using this naming system: "MHAT(your unit designation, date)."

For example, MHAT([redacted]01Sep 04).

Step 2: Complete the worksheets:

- **Workload**
- **Supported Units**
- **Personnel**
- **Miscellaneous**
- **Evacuations**

Any questions regarding this information worksheet may be addressed to LTC [redacted] (see e-mail address below).

Step 3: Return this completed document to LTC [redacted] by 10 Sep 04.

Please send to [redacted]

1. Please enter the number that best reflects your unit's workload by month during the period, 1 April through 30 August 2004.

	April	May	June	July	August	Total
New Patients*						0
All Patient Visits						0
New COSC One-on-One Contacts**						0
All COSC One-on-One Contact Visits						0
Soldiers with Suicidal Thoughts or Behaviors						0
Completed Suicides						0
Soldiers with Homicidal Thoughts or Behaviors						0
Evacuations						0
Soldiers Receiving Restoration						0
Soldiers Returned to Duty From Restoration						0
Soldiers Receiving Reconditioning						0
Soldiers Returned to Duty From Reconditioning						0

** "New Patients" are clinical in nature (i.e., the Soldier is evaluated and treated through traditional behavioral health care). This category accounts for distinct individuals seen by your unit.*

*** "New COSC One-on-One Contacts" are nonclinical in nature (i.e., the Soldier is managed through COSC interventions). This category accounts for distinct individuals seen by your unit.*

2. What source did you use for this data (e.g., COSC-WARS)?	
3. Do you track workload using another database (e.g., a homegrown Excel or Access database)?	

4. List the units that you support and the corresponding distance and travel time from you.		
Unit	**Estimated Distance (in miles)**	**Estimated Time (in hours)**
5. Approximately how many Soldiers are in your sector?		

6. On the average, how many person-hours are lost to non-COSC/BH taskings per week?	
7. How many teams does your unit have?	
8. How many clinicians are in your unit?	
9. How many clinicians are on your unit's modification table of organization and equipment (MTOE)?	
10. How many vehicles are on your unit's MTOE?	
11. How many vehicles does your unit have in its possession?	
12. How many vehicles could your unit dependably borrow if needed?	
13. How many armored vehicles does your unit have?	
14. How many working SINCGARs does your unit have?	
15. What is the medical holding capacity of your unit?	
16. Does your unit have SAWs for use on convoys?	
17. Does your unit have access to a DNVT phone?	
18. Does your unit have access to a secure internet?	
19. Does your unit have access to the nonsecure internet?	
20. Does your unit have access to Motorola Walkie-Talkies?	
21. Does your unit have access to cell phones?	
22. Does your unit have access to satellite phones?	

23. Did you bring psychotropic medication for the purpose of distributing to Soldiers/patients?		*Yes or No*
24. How far away is the nearest pharmacy to refill your medication supplies?		*In miles*
25. How many psychological tests have been performed from 1 April to 30 August 2004?		*Number*
26. How do you order laboratory tests?		*Text*
27. How do you get laboratory test results?		*Text*
28. Are you satisfied with laboratory support?		*Yes or No*
29. Which currently unavailable laboratory tests are needed to adequately care for patients?		*Text List*
30. What medications have you requisitioned (or otherwise acquired) that are otherwise not available in the pharmacy formulary?		*Text List*
31. Do you have a Behavioral Health Casualty Estimate Model? ***If yes, please attach a copy to this completed worksheet.***		*Yes or No*

32. For each evacuation, please provide as much information as possible.

With this information, the MHAT will follow Soldiers and the development of their behavioral health problems as they move through the evacuation chain. Study results will help medical planners improve the efficiency of the evacuation system and the quality of care at each step in the evacuation chain.

	SSN	Unit (Company or Battalion)	Unit (Brigade)	DSM-IV Diagnosis	Month of Evacuation

Thank you for completing this worksheet!

TAB D: Standard COSC-WARS Summary Report (SR) Data Fields

The COSC-WARS, as a data collection system for COSC surveillance and monitoring, has three standard data entry formats: one for summarizing aspects of each preventive contact; one for summarizing aspects of each individual preclinical or clinical contact; and one periodic summary report of selected, rolled-up data from both the preventive and individual contacts. The original Prevention Contacts and Individual Contact forms were not used in OIF-II.

In field operations without COSC-WARS being automated, it is often impractical to fill out each prevention and individual contact form, then transcribe the data from each event sheet into a computer, and do the computations to produce the summary report. Therefore, the COSC-Summary Report form was also designed to be a data collection worksheet for recording and summing the Summary Report data. Immediately after each event, the provider puts a tick mark or Arabic numeral in the space in the row to the right of each relevant data field title. At the end of each reporting period, the tick marks or numerals are summed to give the totals in the far right columns, and the totals for each line (row) from all the providers are summed to give the unit's totals at the end of each reporting period. As with automated roll-down menus in an automated system, only the rows (data fields) that are relevant to the event are used.

The Summary Report form, beginning on the next page, is the one that all (b)(2) Medical Brigade units in OIF-II used. It is the form that (b)(2)-2 Medical Brigade was using at the end of OIF-I, in which they had added 7 lines regarding degrees of suicidal and homicidal behaviors to the original 52-line version. The mental health sections of the Corp's divisions and brigades received the original 52-line version, but some then added or deleted data fields without preserving the original line sequence.

COSC-SUMMARY REPORT– (COSC-SR) – MODIFIED

CONTACT FORM FOR THE SURVEILLANCE OF COMBAT & OPERATIONAL STRESS REACTIONS

1	Unit and Team(s):			
2	Report Dates:		From:	
			Thru:	
3	Location (and/or BCT Supported):			
PRIMARY PREVENTION				
4	# of Critical Event Debriefing Sessions			
5	Total # Attending CEDs			
6	# of Critical Events			
7	# of Other Debriefing Sessions			
8	Total # Attending Other Debriefings			
9	# of Preventive Educational Classes	Enter Sum from Line 10 and Line 12		
10	# of Force Health Protection (FHP) Classes			
11	Total # Attending FHP Classes			
12	# of Mission-Focused Classes			
13	Total # Attending Mission Classes			
SURVEILLANCE ACTIVITIES				
14	# Sensing Sessions/Walkabouts/Focus Groups			
15	Total # Participants/Contributors			
16	# Unit Surveys (Different Units Surveyed)			
17	# Questionnaires (Total Returned in Unit Surveys)			
18	# of Individuals Screened for Pre-/Post-Deployment			
19	# of Individuals Further Screened in Person			
20	# of Individuals Requiring Further Intervention			
21	# Consultations to Command or Other Med Pros			
SECONDARY PREVENTION				
22	Total # of COSR Contacts	Enter Sum from Line 23 and Line 24		
23	# of New Cases (First-time Contacts)			
24	# of Follow-Up Contacts			
25	Operational Causes	# Combat Exposure		
26		# NonCombat Critical Event		
27	Relational Causes	# Peer/Unit		
28		# Leadership		
29		# Home Front		
30	Environmental Factors	# Physical/Environmental Exposure		
		# Other Mission Requirements		
31	Other Individual Causes	# Characterological Factors		
		# Conditional		
		# Preexisting Condition		

TERTIARY PREVENTION			
32	# of Psychiatric/Mental Disorder Contacts	Enter Sum from Line 33 and Line 34	
33	# of New Cases (First-time Contacts)		
34	# of Follow-Up Contacts		
35	# of COSR Patients Who Converted to PMD Patients		
DISPOSITION			
36	# RTD Same Day		
37	# RTD with Administrative Recommendations		
38	# RTD with Limitations Mission Capable		
39	# RTD with Limitations Not Mission Capable		
40	# Rest in Nonmedical Unit (< 72 hours)		
41	# Hold in Medical Unit (< 72 hours)		
42	# Admitted to Ward		
43	# Transfer in Theater		
44	# Recommended/Ordered Evacuated Out of Theater		
COMMAND INTEREST			
45	# Non-mission Capable		
46	# Mission Capable		
47	# of Suicidal Soldiers (also see Lines 53-56)		
48	# of Violent Soldiers (also see Lines 57-59)		
49	# of Command-Directed Referrals		
50	# DA-Mandated Evaluations (e.g., Recruiter Eval)		
51	# Other Command Interest		
52	# of Command Consults re: Individual COSR/PMD Cases		
BREAKOUT OF LINE 47 AND LINE 48			
53	# Soldiers with New Onset/Episode Suicidal Ideations		
54	# New Soldiers with Suicidal Gestures		
55	# New Soldiers with Suicidal Attempts		
56	# Suicides Completed		
57	# Soldiers with New Onset/Episode Homicidal Ideations		
58	# Soldiers with New Onset/Episode Non-homicidal Ideation of Harm Toward Others		
59	# Soldiers Displaying Harmful Behavior Toward Others		

Comments (significant findings and trends, to include those related to Lines 53-59):

APPENDIX 7

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